2006

Registra Mend Item # 10c Per fh g*56 69 5 11 168 to fit Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SANDRA WILLIAMS JUNE 19,2006 3:25 ₺ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MORRIS DULANEY TOWSONBALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X Months Days Hours Min. Yrs. 57 DEC.15,1948 MARYLAND Director 217 56 6646 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD. N/A BALTIMORE Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1240 ROSSITER AVE. 21239 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married 1 ☐ Yes 🏋 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 12TH SUPERVISOR/HOUSEKEEPING HARBOR COURT HOTEL 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic avent QRES. 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 GENE OLIVER MARY LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1240 ROSSITER AVE. BALTO, MD. 21239 WESLEY WILLIAMS (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Ponation 5 Other (Specify) GARRISON FOREST VETERANS CEM. OWINGSMILLS, MD. Mature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO.MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{XOther} \(\text{(Specify)} \) HOSPICE 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Medicai ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 1 2006

ORIGINAL

Sparte

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Yeer Month **Physician** Saundra Wise JUNE 2006 4:00P 15, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F SC 212.52.0848 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County 1 ☐ Yes 2 ☐ No Baltimore MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1526 Burnwood Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ∰No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Ustomer nsurance 12th grade. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Odoms permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If item 27 is marked any injury or other traumatic evone. Sarah James Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NIERE Baltimore MD 21206 Boymans NICOLD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Window Mill, MD Memorial Park 06.21.06 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

27. Name and Address of Facility

28. Name and Address of Facility

29. Name and Address of Facility

29. Name and Address of Facility

20. Name and Na 21. Signature of Funeral Service Licensee M01363 Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC CARCINOMA OF THE LUNG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacço use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform res 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 35 No 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of cer D0017695 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J. HELOU M. D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State Spark 2006 Registrar

DHMH 17 Rev 1/2001

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "neturel", or itams 23s or 28s-1 show other traumatic event, the Madical Examiner must be notified at

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

use as the burial-transit

led by the attending physician detached for use as the buria

page 2 should

the funeral director,

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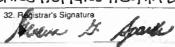
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after death.

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State Registrar 31. Date filed (Month, Pay Year) 1 2006



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	: Dhuaici		1. Decedent's Name (First, Middle, L	.ast)				2. Date of Dear Month		3. Time of Death
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٠.			Friends Nursing 5. Social Security Number 6.		ge (In yrs. last birthday)	Sandy If Under 1 Year	Spring	S. I 9 Date of Birth	Mont	Eighnery
П	Funeral Director		133-22-9661	15€M 2□F	77 Yrs.	Months Days	Hours Min	. (Month, Day,		Birthplace (State or Foreign Country)
			Usual Residence of Decedent					07-31-	1928	Georgia
	rytan		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
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Baltimore,	permit. Pages 1 Depirtment of He Important: If iten any injury or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 1 □ Donation 5 □ Other (Special Control of		20b. Place of Dispo cemetery, crea Chesapeal	matory or other pla			20c. Location - Cit Beltsvi	y or Town, State
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on	th. : After funer	tior	1 Natural 5 Pending 2 Accident investigat	(Month, Da	ay Year) Injury	Wor	rk? Yes 2.∐No		,,	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not determine	be 28e. Place of In	jury - At home, farm, sti tc. (Specify)	reet, factory, office		28f. Location (Sti City or Town	reet and Number o	or Rural Route Number,
	Hospital 24 hours a Funeral Ditely filled		29a. Certifier Toccertifying	Physician: To the best	of my knowledge, deat	occurred at the til	me, date and place	a and due to the ca	use(s) and manne	ar as stated
	e Hos 124 h e Fur	Medical		eminer: On the basis of and manner si	of examination and/or in	vestigation, in my o	ppinion, death occi	urred at the time, da	ite and place, and	due to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier	1		29c. Licens	e number	29	d. Date signed (A	Nonth, Day, Year)
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	Registr	ar	JUN 2 1	2006	ever St. A	108461				

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar		Certificat	e of Death		, g	eg No 2	006 1950
Physicia	ın/	 Decedent's Name (First, Middle 					2. Date of Dea Month	Day Year	3. Time of Death 2002 hrs
/ledical Examii	ıer	Michele Bonnie 4a. Facility Name (if not institution			4b. City, Town,	or Location of	June 18, 2	4c. County of	
		Franklin Square Hospi	-		Rosedale			Baltimore	
Funeral Director	- 1	5. Social Security Number 218 68 3237	6. Sex 7. Age (In 1) 7. Age (I	n yrs. last birthd	*	ear If Under 2 ays Hours		13 1971	9 Birthplace (State or Foreign Country Land
daryland 28a-f show any <u>1 at once.</u>		Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo		c. City, Town or Baltimore			-		10d. Inside City Limits 1 Yes 2 X No
death with the Maryland or items 33a or 38a-f sho must be notified at once	Director	10e. Street and Number 1821 Willann Road			10f. Zip Code 21237		1	0g. Citizen of What	t Country?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divo 15. Decedent's Education (Spec	1 Yes 2 X orced If Yes, Give Year or Dates:	No	3. Was Decedent of I If Yes, specify Cub 1 Yes 2 X I Cedent's Usual Occup	an, Mexican, P		14. Race - White, Specify:	White
5-0036 led within 72 hour tygiene other than "natu	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		ing most of working l			Cooking :	,
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be	17. Father's Name (First, Middle, Faward Wade				Bonnie	Name (First, Middle, e Slitzer	,	
MD 2' and 2 should ealth and M em 27 is ma	2	19a. Informant's Name/Relationsh Bonnie LaPausky (20a. Method of Disposition	nip (Type, Print) (Mother)	37		al Hill	er or Rural Route Nur Road Jarrett Date	sville, Ma	State, Zip Code) ryland 21084 ity or Town, State
Baltimore, permit Pages 1 ar Department of Hes important: If ite				crematory	ematory Inc	June 2	2006	Baltimore	
Physician in	ś	23a. Part I Enter the disease, or o	n Characki	death. Do not e	22 Name and Addre Lassann Fu 7401 Relai	r Road P	altimore.Mar	vland 21236 st, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	on each line. a. Methadone into Due to (or as a conseque						Between Onset and Death
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseque	ence of):					
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760, cate be execut physician and he burial - tra	Medical	X UNPENDED IF FEMALE:	23c. If yes, outcome of		,,201 1,pciri	2,6037,77	15/00 11	23d. Date of de	Plivery
Box 68760, e death certificate by the attending physic ed for use as the but	siciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unk	e 1 Live birth 4 Pregnant at time	2	Fetal death Other (Specify)	B Ectopic p	regnancy	Month	Day Year
, P.O. E ires that the d signed by the	Ē	Part II. Other significant conditi		it not resulting in	n the underlying caus	e given ın Part	1		ite to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed						24a. Was autop perfo 1 Ves	osy prio rmed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
tal R cian: T certific ector, p	ادہ	25. Was case referred to medical examiner?			26.Pla	ce of Death (C			
of Vit ling Physic After this c funeral dire	n: To B	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year)	2 E R/Outp	ne of Injury 28c. Ir	njury at Work?	28d. Describe	Residence 6 how injury occurred	Other:
ision Attendi er death rector: A	ertification		Fnd 6/18/20		5:45 pm 1	Yes 2 N	28f Location (Street and Number	or Rural Route Number, City
Divis Hospital or At 24 hours after d Funeral Directely filled in by	O	4 Homicide	not be	nd in res	idence		Rosedale 1	state) 1821 Wi D	lliam Road
To the Hos within 24 h To the Fun completely	edical		niner: On the basis of examina and manner stated	ation and/or inve	estigation, in my opini	on, death occu	rred at the time, date	and place, and due	to the cause(s)
	ž	29b. Signature and title of certifier	Halla	W		nse number		June 19, 200	(Month, Day, Year) 06
10			sistant Medical Examin	er 111 Pe	enn Street, Balti	more, MD 2	21201		No.
St Regist	ate trar	31. Date filed (Month, Day, Year)	2006 32. Registrar's S	1.	bracks				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Williams June 17 2006 11:40 Edward Charles 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 16,1942 9. Birthplace (State or Foreign Country) South Carolina 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1⊠M 2□F 63 247-68-5721 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Upper Marlboro MD Prince Georges 11 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 17116 Fairway View Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Mever Married 2 Married Specify: Black 1 Tes 2X No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Private 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charlie Williams Vernell Gadson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles T. Williams/Son 11810 Brandywine Rd., Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Washington Nat'l Cem. June 23,2006 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd., Landover, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE Due to (or as a consequence of): PER TENSION Due to for as a consequence of: Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No 1 Yes 26. Place of Death Check only one Hospital: 1 X Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Examine

Physician/Medical

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Completed

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Certification:

Medical

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If Item 27 is marked other 11 eny injury or other treumatic event, this once.

Physician

/Medical

Examiner

Funeral

Director

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Saltimore, Maryland 21215-0036

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The law requires that the death certificate be executed n 24 hour. the Funeral Dire within 2 To the

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar

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31. Date filed (Month, Day, Year) JUN 2 1 2006

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6192 OXON HILL ROAD #500 32 Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 17 2006 Ward 0del1 **Physician** Verlin 9:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 771 209th Street Pasadena Anne Arundel County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□F Months 289-36-7244 Director 65 Feb 8. Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 27 is marked other then "naturel", or Itema 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Pasadena Maryland Anne Arundel 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 771 209th 21122 Street USA Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1959-61 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Locke Insulator Chemist Ô permit. Pages 1 and 2 should be file.
Deperment of Health and Mental Hygher any Injury or other the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel 1 Ward Viola (Unknown) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Grandson) 209th St., Pasadena, Maryland George Woodward 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Pk. 6/22/06 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie nsee Kevin E McCully-Polyniak Funeral Home, P.A. 21230 Ecker 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIDPUZMONARY ARREST **Physician** disease or condition resulting in death) /Medical SPIRATORY FAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physicien and for use as the burial-transit RUCTIVE LUNG DISESE The law requires that the death certificate be executed HRONIC that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery NIA 3 DEctopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 21 No 1 Yes 20 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) မှ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. М 1 Tes 2 No 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Dire 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature ar 29c. License number 06/19/06 ()42041 d cause of death (Item 23a) (Type, Print) Hwy. Brooklyn Park. MD 21205 4115 31. Date filed (Month, Pay, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June **Physician** Charles O. Wessel, Sr. 2006 0045 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Campus Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 31, 1 9. Birthplace (State or Foreign Country)
MaryLand 6. Sex **Funeral** Days 1∭M 2□F 215-09-8433 89 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 7 is marked other then "natural", or items 23e or 28e-f show traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Maryland Director Harford Fallston 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 909 Monte Avenue 21047 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "natural, or item any injury or other traumatic event, its Mudical Fundament Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Wessel (names unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joyce Zahner (daughter) 909 Monte Avenue, Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem'l 6/23/2006 Timonium, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Septice Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TRANSITIONAL CELL CARCINOMA **Physician** 10 MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed inding physicien and use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 12 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 PNo To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Pinpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ANatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EYWANDS FAUSTON 31. Date filed (Month, Day, Year) 32: Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		tificate of		d Wichta		eg. No.	005 1051
Physicia	an/	Decedent's Name (First, Middle,Last)					2. Date of Dea	ith	3 Time of Death
Medical Exami	ner	Samuel A. Woodall					Month June 15, 1	2006	0245 hrs
		4a. Facility Name (if not institution, give street and number) University Specialty Hospital		4	b. City, Town, or Baltimore	Location of E	Death	4c. County	of Death
Funeral			(In vrs. las	st birthday)	If Under 1 Yea	ar If Under 2	24Hrs 8 Date of Ri	th(MM/DD/VVV)	9 Birthplace (State or
Director		214-68-6555 1 ^X M 2 F		Yrs	Months Day		Min.		Foreign Country) Italy
	- 1	Usual Residence of Decedent	41	115			Apr.	28 1965	country) I tally
amy	Ì	10a. State 10b. County	10c. City, 7	Town or Location	on			-	10d Inside City Limits
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Maryl: 28a-f	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wi	hat Country?
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ith wit tems 2	Funeral	11. Marital Status 12. Was Decedent Armed Forces?					? (Specify Yes or N o uerto Rican, etc.)		e - American Indian, Black, e, etc.
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5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examine	d b	or Dates: 15. Decedent's Education (Specify only highest grade com	pleted)	16a. Decedent	s Usual Occupa	tion (Give kin	white d of work done		white usiness/Industry
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)	during mo	st of working life	. DO NOT us	e retired)		
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21215-0036 Wild be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last) Samuel A. Woodall Sr.					Name (First, Middle, 1 ra Dunham	Maiden Surname)
T. 2 0 5 5 1	o Be	19a. Informant's Name/Relationship (Type, Print)		19b Mailing	Address (Stree		r or Rural Route Nur	nher City or Tou	n State Zin Code)
MD 21 nd 2 should balth and Mer m 27 is mar aumatic eve		Erica A. Butler - Sister	-	9.0					elaware 19960
4 E & B B	İ	20a. Method of Disposition	20b. Pl		ion (Name of ce		Date		- City or Town, State
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Baltimore, permit Pages I as Department of He. Important: If ite	ı	21. Signature of Funeral Service Licensee		22 Na	me and Address	s of Facility			
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Physician /Medical		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	he death. I	Do not enter the	e mode of dying,	such as card	liac or respiratory arr	est, shock, or he	art Approximate Interval Between Onset and
çxaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse			with comp	lication	ns		Death
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Vital F ysician: his certifi director,	Be	25. Was case referred to medical examiner?			26.Place		neck only one)		-
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been set in by the funeral director, page 2 should.	힏	1 ✓ Yes 2 No		R/Outpatient				Residence 6	Other:
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Division piral or Attentours after death eral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)			, , , , , , , , , , , , , , , , , , , ,		or Town, S		or real real real real real real real rea
Hosp 24 hor Fune	- 1	29a. Certifier (Check only 1 Certifying Physician: To the best of my	knowledge	e, death occurre	ed at the time, da	ate and place,	and due to the caus	e(s) and manner	as started.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner:On the basis of exam and manner stated.	ination and	d/or investigatio	n, in my opinion	, death occur	red at the time, date	and place, and d	ue to the cause(s)
. > . 0	ž	29b. Signature and title of certifier			29c. Licens			29d. Date signe	ed (Month, Day, Year)
		Theodor M. Kery		(fee	O.C.I	M.E.		June 16, 20	006
4	Ì	30. Name and address of person who completed cause of the Thought Name and Address of person who completed cause of the Thought Name and Though Name and	ath (Item 2	111 0	n Chanal D	ltimore 14	D 21204		
	nte.	Theodore King MD. Assistant Medical E 31. Date filed (Month, Day Year) 32. Rigistrar	s Signature	a /	n Street, Ba	шпоте, М	D Z 1ZU 1		
St Regist	ate. .rar	31. Date filed (Month, Day Year) JUN 2 1 2006 32. Fustrar	e S	4 Apr	the same				

	1- For State Registrar	•	epartment of Health and Certificate of Death	Reg.	No. 19311
Dhusisia	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Yeer 3. Time of Death
Physician /Medical	Rita Barbara Zande				16, 2006 0002 A M
Examiner	4a. Facility Name (If not institution, give stree	et and number)	4b. City, Town, or Location of Dea	h	4c. County of Death
We have	Upper Chesapeake	7. Age (In yrs. last birtho	Bel Air	9 Date of Righ	Harford
Funeral Director	5. Social Security Number 6. Sex		Months Days Hours Min	(Month, Day, Ye.	
	179-26-8722 Usual Residence of Decedent	/1		Dec. 9, 1	934 Pennsylvania
Maryland -f ahow	10a. State 10b. County	10c. City, Town o	or Location		10d. Inside City Limits
the Marylan 28a-f ahow notified at	Maryland Harford		Abingdon		1 ☐ Yes 2 X No
with the Mar a or 28a-f a De notified	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	2915 Craigston Lane	2	21009		U. S. A.
Sinter death virtema 23	11. Marital Status 12.		13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify
003(003)	3 X Widowed 4 □ Divorced	Year or Dates:		1/40	White
21215-00 ed within 72 hou sygiene. In the Medical It. It is Medical It. The Medical It.	15. Decedent's Education (Specify only highest grade co	mpleted) (C	lecedent's Usual Occupation Give kind of work done during most of wo ife. DO NOT use retired)		. Kind of Business/Industry
212: 212: 3d withir 9giene. •r than		College (1-4or 5+)	Homemaker		Own Home
a filed with Hygiene other than vant, the Commission of the Commis	12th Grade 17. Father's Name (First, Middle, Last)			me (First, Middle, Maid	
land land land land land land land land	Albert S. Gayhart		Rar	bara Portle	a v
larylan 2 should be and Mental 1a marked d aumatic av	19a. Informant's Name/Relationship (Type,	Print) 19b. N	Mailing Address (Street and Number or R		
Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma M	Frederick J. Zander		1 Grier Nursery Rd	Forest H	Hill, Maryland 21050
Baltimore, Maryland 21215-003 permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hyghene. Important: If Item 27 Is marked other than "natural; any highry or other traumatic avent, the Medical Exagonce. To Be Completed by	20a. Method of Disposition	20b. Place of D	Disposition (Name of crematory or other place)		. Location - City or Town, State
ages ant of triff if it	1 XBurial 2 □ Cremation 3 □ Remarks 4 □ Donation 5 □ Other (Specify)	oval from State	Mem. Gardens 06/2	0/2006 Be	1 Air Maryland
ingramme in the control of the contr	21. Signature of Funeral Service Licensee	DCT ATT			
D	16/11		22. Name and Address of Facility Schimunek Funeral 610 W. Macphail Ro	Home of Be	l Air, Inc.
	23a. Part1. Enter the disease, or complicati	ons that caused the death. Do not	-		Approximate Interval Between
	shock, or heart failure. List only one c	ause on each line.			Onset and Death
Physician / /Medical	disease or condition resulting in death)	Due to (or as a consequence of)	· XSX		N (days
Examiner		Acut. Re	mal Lailus	1	N 6 dous
in the second	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of)	1	£	1000
executed executed in and inal-transit	cause. Enter Underlying Cause (Disease or injury that initiated events	Atrial	librillation		~ Toloren
60, be executed ician and burial-transit	resulting in death) Last	Due to (or as a consequence of)			1
760, 16 be ev ysician ie buria	d				
as the					
P.O. Box 68 nat the death certifical by the attending philaded for use as the Physician/Med	23b. was decedent pregnant	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery
the deat hed for the form	in the past 12 months?	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month Day Year
of Vital Records, P.O. Physician: The law requires that the daths certificate has been signed by the rial director, page 2 should be detached.	9 Unknown	300111101111			
ds, Fd iries that signed I be det	Part II. Other significant conditions contrib	*	he underlying cause given in Part I.		co use contribute to the cause of death?
Cord	Dementi	a		1 🗆 Yes	2 No 3 Probably 4 Unknown
ITAM RECORDS Lital Records cian: The law requires retrificete has been sign sector, page 2 should be Recompliated by				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
F Vital Recysician: The lay ysician: The lay is certificate has director, page 2				performed 1 ☐ Yes 2 🔀	? death?
Vital F	25. Was case referred to medical		26. Place of De	ath (Check only one)	
hysical direct	examiner? 1 ☐ Yes 26€No Hosp	oital: 1 Inpatient 2 ER/Outp	atient 3 DOA Other: 4 Nursing	Home 5 Residence	6 Other (Specify)
O de de la constant d	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at	28d. Describe how in	
indin indin	1 Natural 5 Pending 2 Accident investigation	(North, Day You)	M 1 Yes 2 No		
Division of Division of State death.	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
S affect of the state of the st	To the state of th	building, old. (opcony)			
Hospit Hospit Puners Funers telly filled			faith occurred of the time. Italia and practical in my enight death and		
8 0 mg 8	one)	and manner stated.	or investigation, in my opinion, death occ		
To the within To the company company	29b. Signature and title of certifier		29c. License number	- A	Date signed (Month, Day, Year)
	Schoole M.D.		D56545	6/	16/06
• • •	30. Name and address of person who comp	leted cause of death (Item 23a) (T	ype, Print)	> 10.11.	*
10	SHILPI KHOSLA, 20	6 HAYS ST #10	2, BEL AIR, MI	21014	
State	31. Date filed (Month, Day, Year)	32 Degistrar's Signature			
Registrar	JUN 2 1 2006	Brauce H.	perti		
DHMH 17 Rev 1/200					

ORIGINAL

			For Stata Ragistrar	State of	Maryland /	•	irtment <i>tificate</i>			ind M		giene leg. No	(UUb	19512
			Decedent's Name (First, Middle, L.	ast)							2. Date of Dea	ith		3. Time of Death
	Physici		Eliner Sanders	. Zimmerm	an						June 15	Day O		2:15 P M
3	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, T	own, or	Location o				County of Death	
Ĉ.	Examin	ICI	11630 Glen Arm			1	G1e	en A	r m			В	altimore	1
	Funeral	2			Age (In yrs. last b	irthday)	if Under 1	Year	If Under a	24 Hrs.	8. Date of Birth)		place (State or Foreign intry)
	Director		147-09-9716	1□M 2□F	96	Yrs.	Months	Days	Hours		Dec. 22	2, 1	909 Mary	land
	P .		Usual Residence of Decedent		10- Ch. T-									
	aryla	L.	10a. State 10b. County		10c. City, To		cation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Director	MD Baltimo	ore	Glen	Arm	1							
	with ti	吉	10e. Street and Number	_			10f. Zip (10g. Cit	izen of What Cou	intry?
	within 72 hours after death with the Maryland one. Itan "naturel", or items 23a or 28a-f ehow the Moulpal Exact for most be notified at	Funeral	11630 Glen Arm		The state of the s	100	210			:-0 (0	-# W N-		USA 14. Race - Amer	inn ladin
	er de Item	nu.	11. Marital Status	12. Was Decede	es?	13. V	Yas Decede f Yes, specif	fy Cuba	n, Mexican	, Puerto l	cify Yes or No- Rican, etc.)		Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1	☐ Yes 2	No 🖸	Specify:	whi	te		Specify: Whi	te
阜	ture sture	ed	15. Decedent's I			a. Deced	lent's Usual	Occupa	ition			16b. K	ind of Business/li	ndustry
5	in 72	Completed	(Specify only highest g			(Give .	kind of work OO NOT use	done d	u <i>rina m</i> ost	of workii	ng			,
212	T the state of the	E	Elementary/Secondary (0-12)	College (1-4	01 34)	Sec	cretar	ĵу				Cr	edit Uni	.on
פ	othe vent,	Bec	17. Father's Name (First, Middle, Las	it)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
<u> </u>	ould be filed v Mental Hygie tarked other t tatic event, ID	2	Daniel Sanders	5						Ga	rdner			
፟፟	2 should and Men is marks eumatic		19a. Informant's Name/Relationship		19	b. Mailin	g Address (Street a	ind Numbe	r or Rura	l Route Numbe	r, City o	r Town, State, Zi	p Code)
	end 2 ealth n 27		William Zimmermar	ı III - So					Drive				d 21140	
ore.	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Removal from St	20b. Place cemet	of Dispos ery, crem	sition (Name natory or oth	e of ner place	9)	D	ate	20c. Lo	ocation - City or T	own, State
Ĕ	Pages ment of ant: If its ury or o		4 Donation 5 Other (Spec				emator		J	une	17, 06	Bal	timore M	aryland
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Healin and Mental Hygiene. Depertment of Healin and Mental Hygiene. The many state of Healin and Mental Hygiene. The many injury or other treumatic event, the Musical Examinar must be notified at once. Once.		21. Signature of Funeral Service Lice	n ene		22	. Name and	Addres	s of Facility	, ietv	of Mar	vla	nd, Inc.	
ш	70 E 9 9		"HUIK &	SCHOOL	Mgs	7	19 Hre	rabr	ick R	oad	Raltimo	re	MD 2122	.8
п			23a. Part. Enter the disease, or conshock, or heart failure. List only	mplications that cau y one cause on eac	sed the death. Do h like.	not ente	er the mode	of dying	g, such as	cardiac o	r respiratory ari	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. A.	ENOC	AR	CIR	101	mA	٥	VE THI	=	LUNG	2 month
E.	/Medical Examiner		resulting in death)	Due to (or	as a consequence	e of):								
		7	Sequentially list conditions,	b. — Due to (or	as a consequence	a of):								
	bed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D40 10 (G	as a consequence	5 017.								
	xecur and al-tra	xar	that initiated events resulting in death) Last	c Due to (or	as a consequence	e of):								
760,	ite be executed sysicien and ne burial-transit	calE		d										
	ificate g phy as the	edic		0.										
Вох	w requires thet the death certificat been signed by the attending phy should be detached for use as th	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								:	23d. Date of deliv	rery
m ·	death e atte	icia	in the past 12 months?	4□Pregnan	n 2 🗍 Fetal death		Ectopic pre Other (s <i>pe</i>						Month	Day Year
P.O.	at the by th tache	hys	9 Unknows	9∐ Unknow	n 									
S,	as the gned	by F	Part II. Other significant conditions	contributing to deal	h but fot resulting	in the ur	derlying car	use give	n in Part I.		23e. Did to	bacco u	ise contribute to	the cause of death?
ğ	en sig		pemen	Marsh	mle:		1				1 🗆 Y	es 2	No 3□ Pro	bably 4 🗍 Unknown
O.	law re es be 2 sh	Completed	Phenner	10.	3110	nay	1						24b. Were aut	opsy findings available
ည္မ	e 4 e	E		VICE	2 6 2017	/ 00-	-				24a. Was a		prior to co	empletion of cause of
Rec	Da ate	<u> </u>	,	1	J C ~ 2/12	, 0,00	-			_	autop: perfor	sy med2	prior to co	ompletion of cause of
ital Rec	ian: The		25. Was case referred to medical	1	3 (2017)	, 0, 0			26. Place	of Death	autop: perfor	med 2 No	prior to co	ompletion of cause of
f Vital Rec	hysician: Thinis certificate	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inp	atient 2 ER/C	Outpatien	t 3 DOA	Othe			autop perfor 1 Yes	med 2 Mo ne)	prior to co	ompletion of cause of 2♥ No
n of Vital Rec	ng Physician: Th Iter this certificate ineral director, pa	To Be	examiner? 1 ☐ Yes 2 ☑ No 27. Manger of Death	28a. Date of		Outpation Time of Injury		Othe	r: 4 □ Nui	rsing Hor	autop perfor 1 Yes	med 2 Mo ne) ence	prior to od death? 1 □ Yes	ompletion of cause of 2♥ No
sion of Vital Rec	tending Physician: The eath. or: After this certificate the funeral director, pa	To Be	examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of (Month,	Injury 28b	. Time of		c. Injury Work	r: 4 □ Nui	rsing Hor	autopperfor 1 Tes (Check only or	med 2 Mo ne) ence	prior to od death? 1 □ Yes	ompletion of cause of 2♥ No
ivision of Vital Rec	or Attending Physician: The death. Mector: After this certificate In by the funeral director, pa	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month, on be 28e. Place of	Injury 28b	Time of Injury	м 28	c. Injury Work	^{AC} 4□ Nui at ?	rsing Hon	autopperfor 1 Yes (Check only or ne 5 Resid	med 2 No 2 No ne) ence (ow injur	prior to cc death? 1 Yes 6 Other (Specify occurred	ompletion of cause of 2♥ No
Division of Vital Records,	of a strending Physician: The law requires thet the death certificature of the death certificature blrector: After this certificate has been signed by the attending phylied in by the tuneral director, page 2 should be detached for use as the	Certification: To Be	examiner? 2. Manper of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not determine	28a. Date of (Month, on be d building	Injury 28b Day Year) Injury - At home, , etc. (Specify)	Time of Injury farm, stre	M 28	c. Injury Work 1 🔲 Y	at ? Yes 2 Nu	rsing Hor	autop. perfor 1 □ Yes (Check only or ne 5 V Resid 28d. Describe h 28f. Location (S City or Tow	med 2 2 M No ne) ence (ow injur treet ann, State	prior to cc death? 1 Yes 6 Other (Specify occurred	ompletion of cause of 2 12 No (y) al Route Number,
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Division of Vital Rec	Hospitel 4 hours e Funerel (To Be	examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending investigati 3 Suicide 6 Could not determine 29a. Certifier (Check only one) 1 Certifying F 2 Medical Examine	28a. Date of (Month, on be d 28e. Place of building	Injury Day Year) Injury - At home, etc. (Specify) est of my knowleds of examination a	Time of Injury	M 28 M occurred a vestigation, i	office	at ? /es 2 1	No 2	autopperform 1 □ Yes (Check only or ne 5 N Reside 28d. Describe h 28f. Location (S City or Tow and due to the code at the time, code	ence ow injur treet ann, State ause(s)	prior to country 1 Yes	ompletion of cause of 2 12 No (y) al Route Number, stated. o the cause(s)
Division of Vital Rec	To the Hospitel or Attending Physician: The law within 24 hours elter death. Within 24 hours elter death. To the Funerel Director: Attenthis certificate hes completely filled in by the funeral director, page 2	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manper of Death 1 Accident 3 Suicide 6 Could not determine 29a. Certifier (Check only) 1 Yes 2 No 5 Pending investigati 6 Culd not determine	28a. Date of (Month, on be d 28e. Place of building	Injury Day Year) Injury - At home, etc. (Specify) est of my knowleds of examination a	Time of Injury	M 28 M occurred a vestigation, i	office	at ?? (es 2 1 h	No 2	autopperform 1 □ Yes (Check only or ne 5 N Reside 28d. Describe h 28f. Location (S City or Tow and due to the code at the time, code	ence ow injur treet ann, State ause(s)	prior to death? death? 1 Yes 6 Other (Special Yourned)	ompletion of cause of 2 12 No (y) al Route Number, stated. o the cause(s)
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	Hospitel 4 hours e Funerel (edical Certification: To Be	examiner? 1	28a. Date of (Month, on be de 28e. Place of building Physician: To the baminer: On the bas and manne	Injury Day Year) Injury - At home, etc. (Specify) est of my knowled of of examination are stated.	Time of Injury farm, stre	M 28 M occurred a vestigation, i 29c.	c. Injury Work 1 1 1	e, date and injumber	No 2 d place, a ch occurre	autopperfor 1 Yes (Check only or ne 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the c ad at the time, c	ence ow injur treet ann, State ause(s)	prior to country 1 Yes	ompletion of cause of 2 12 No (y) al Route Number, stated. o the cause(s)
	To the Hospital within 24 hours e within 24 hours of to the Funeral completely filled	Medical Certification; To Be	examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending investigati 3 Suicide 4 Homicide 6 Could not determine 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of (Month, on be de 28e. Place of building) Physician: To the barniner: On the bas and manne	Injury Day Year) Injury - At home, etc. (Specify) est of my knowled of of examination are stated.	Time of Injury farm, stre	M 28 M occurred a vestigation, i 29c.	c. Injury Work 1 1 1	at ? /es 2 1	No 2 d place, a ch occurre	autopperfor 1 Yes (Check only or ne 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the c ad at the time, c	ence ow injur treet ann, State ause(s)	prior to country 1 Yes	ompletion of cause of 2 12 No (y) al Route Number, stated. o the cause(s)
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	To the Hospital Within 24 hours & Within 24 hours & To the Funeral Completely filled	Medical Certification; To Be	examiner? 2. Manper of Death 1 Postural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person where the control of the certifier 31. Date filed (Month, Day, Year)	28a. Date of (Month, on be de 28e. Place of building 28e.	Injury Day Year) 28b Injury - At home, etc. (Specify) ast of my knowled is of examination a stated.	farm, stre	M 28 M occurred a vestigation, i 29c.	c. Injury Work 1 1 1	e, date and injumber	No 2 d place, a ch occurre	autopperfor 1 Yes (Check only or ne 5 Resid 28d. Describe h 28f. Location (S City or Tow and due to the c ad at the time, c	ence ow injur treet ann, State ause(s)	prior to country 1 Yes	ompletion of cause of 2 12 No (y) al Route Number, stated. o the cause(s)

			1 - For State Registrar	State of Mai		epartme C <i>ertifica</i>			Mental Hy	/gien Reg. N	Em U U	5	19513
	Physici		1. Decedent's Name (First, Middle, Las Alberta	Aqui					2. Date of D June	3, 2	006 Yea	ır	3. Time of Death 11:30 p M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		S		ocation of Death Sprin If Under 24 Hrs.	g	40	. County of De	ome	ry
	Funeral Director		5. Social Security Number 6. S 579-14-4755 Usual Residence of Decedent	□M 2 X F		rs. Month		Hours Min.	8. Date of B (Month, D	/19		ash	e (State or Foreign
	e Marylan a-f ehow	ctor	MD Howard		Colum							10d.	Inside City Limits 1 ☑ Yes 2 ☐ No
	sth with the 23a or 28 ust be no	ral Director	10e. Street and Number 6158 Stevens I	Forest Ro	ad		Zip Code 210				USA		
036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "naturel", or Itema 23a or 28a-f show sumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			edent of His ecify Cuban 2 X No	panic Origin? (Si , Mexican, Puerto Specify:	pecify Yes or N p Rican, etc.)	0-	14. Race - Ar Black, W Specify:		
Maryland 21215-0036	within 72 ho lene. then *natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)			life. DO NOT	vork done du	iring most of wor	king		S.Pos		
פק	be filed w ntal Hygier od other th	BeC	17. Father's Name (First, Middle, Last)		I			18. Mother's Nam	ne (First, Middle	e, Maide	n Sumame)		
<u>ya</u>	Menta Arked	Tof	Albert Brooks						e unkr				
, Mar	and 2 sh salth and n 27 le m		19a. Informant's Name/Relationship (Leona McDaniels	**	r 7	611 M	aple	Avenue	#411	Tak	oma Pa	ark	, MD
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Ie marked eny Injury or other treumatic en 200c.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	20b. Place of I cametery. Ches	apeak	e Cre	m 6/07		Ве	ocation - City	lle	, Md
Balt	permit. Depart Import eny Inj		21. Signatur Juneral Service Vor	1111 /		PHIL 9241	and Address IP D.	of Facility RINALD	I FUNE	ERAL	SERV:	ICE,	,P.A.
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused to one cause on each line	ne death. Do no	ot enter the m	ode of dying	such as cardiac	or respiratory	arrest,	r opr.	Ini	oproximate terval Between nset and Death
	/Medical Examiner		resulting in death)	Due to (or as a		•							
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Gangre				· .					
68760,	ficate be executed physicien and s the burial-transit	al Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	c. Derip n Due to (or as a	consequence of	ascul	ar di	sease				-	
_	= 00 m	ledical		. 0.									
P.O. Box	The law requires thet the death certifi sie has been signed by the ettending I age 2 should be deteched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 Ectopic 5 Other (23d. Date of o Month	delivery Da	y Year
rds, P	w requires thet the de been signed by the e should be deteched f	by	Part II. Other significant conditions of	•	not resulting in	the underlying	cause giver	n in Part I.					eause of death? y 4 ∰Unknown
Division of Vital Records,	i: The law re icete has be : page 2 sh	Completed							24a. Wa auto per 1 Yes	opsy formed?	prior t death	o compl	r findings available letion of cause of No
*	slciar certif irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2∑ No	Hospital:	2 ☐ ER/Out	notions 201	Other	26. Place of Dea 4⊠ Nursing H			6 Flore - (C	6)	
on of	Attending Physician: r death. sctor: After this certific by the funeral director.		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	28b. Ti		28c. Injury Work		28d. Describe			респу)	
Divisi	ef or Atter s effer dea d Director d in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined			m, street, facto	ory, office		28f. Location City or To	(Street a own, Stat	nd Number or 'e)	Rural R	oute Number,
	To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edicai C		ysician: To the best of niner: On the basis of e and manner state	xamination and								
)	To the within To the comp	Me	29b. Signature and title of certifier	0 0	0	sert 2	9c. License D522				une 5		
			30. Name and address of person who Alan R.Segal				n Rd.	Silve	r Spri	.ng,	Md 209	910	
	Sta Registi		31. Date filed (Month, Day, Year)	006 Registrar	s Signature	gove !	,						

			1 - For State Registrar	State of Maryland	/ Department of He		ntal Hygier	2000	19514
			Decedent's Name (First, Middle, L.)	ast)			. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		WILLIAM I	3. ALLEN			June .	5 2006	1115 M
	Examin		4a. Fecility Name (If not institution, g		4b. City, Town, or L	-1		4c. County of Death	NICD.
			Peninsula Region 5. Social Security Number 6.	Sex 7. Age (In yrs. las	t birthday) If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	WICON 9. Birtho	lace (State or Foreign
ı	Funeral Director		152-47-5183	1/2M 20F 54	Yrs. Months Days	Hours Min.	(Month, Day, Ye	ar) Cour	MICH
	σ		Usual Residence of Decedent 10a. State 10b. County	10c City 7	Town or Location			1	0d. Inside City Limits
	faryia	ō	1	ESTER Z	BERLIN				1 Yes 2 No
	the h	Director	10e. Street and Number	100/67	10f. Zip Code		10g.	Citizen of What Cour	ntry?
	th with	aiD	10218 OLD DCE,	AN CITY BLVD	2181	1		USA	
	toms	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Speci , Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Bleck, White,	etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 □Yes 2 1 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: B	LACK
21215-0036	within 72 hours after deeth with the Maryland ane. then "natural" or Items 23a or 28e-f ehow ha Mayleal Exaction must be notified at	ted	15. Decedent's (Specify only highest g		16a. Decedent's Usual Occupat (Give kind of work done du	tion	165	. Kind of Business/In	dustry
218	within 7 iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		_ /	20100	Day
	filed w Hygier other th	Ö	17. Father's Name (First, Middle, Lat	st)		AGEME A 18. Mother's Name (First, Middle, Maid		PRY
and	ld be i	To Be	ILREAL B. (ASH		ANNIE	RUTH	AllEN	}
Maryland	and M and M is mar	1	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street ar			ity or Town, State, Zip	Code)
	end 2 lealth m 27 th		CORDELIA STA	TON-SISTER.	3/0-GARDNER ce of Disposition (Name of	RHYE, TA	ENTON		618 own, State
Baltimore,	nit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan ertment of Health and Mental Hygiene. ortant: If items 27 is marked other than entural; or items 23a or 28e-f show injury or other traumatic event, the Marileal Examinar must be notified at injury or other traumatic event, the Marileal Examinar must be notified at 28.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State cerr	netery, crematory or other place		1, 7	Series	1/T
Ħ	permit. Page Depertment o Important: If eny Injury or once.		4 Donation 5 Other (Special Service Line)	111-	22. Name and Address	s of Facility	FUNIE S	SOITH F	H
Ba	permit. Depertr Imports eny inj		Dollar V. E	rince	917-W.Is	ABELLA.	ST. SA	USBURY A	10, 2/80/
			23a. Parti. Enter the disease, or co sheck, or heart failure. List on	mplications that caused the death. ly one cause on each line.	Do not enter the mode of dying	, such as cardiac or	respiratory arrest,	//	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. Aguired II	mmune Def	iciency	Syndr	one	Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	nce of):	nwilms	.0.1.0		
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons = ue	nce of):	1/1/4/190	11.4		
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.					
,094	tte be executed tysician and he burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):				
687	# × 6	dical		d					
Box (death certificat e ettending phy ed for use as th	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand				23d. Date of deliv	өгу
œ.	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea				Month	Day Year
P.O.	that the led by t detach	Phy	9 Unknown Part II. Other significant conditions	s contributing to death but not result	ing in the underlying cause give	n in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
ds,	Se G ed	d by			,,,		1 ☐ Yes	2 No 3 Pro	bably 4 □Unknown
00	s been s should	Completed					24a. Was an	24b. Were auto	opsy findings available impletion of cause of
- Re	The lav	mo					autopsy performed 1 ☐ Yes 2 ☑	d? death?	2□ No
/ita	Physicien: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Otho	26. Place of Death			
of	Phys this ral dii	. To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 E	R/Outpatient 3 DOA 28c. Injury Injury Work	4 Itursing nom	e 5 🗌 Residence 3d. Describe how	e 6 ⊡Other (Speci injury occurred	(y)
ion	Attending Phy r death. ctor: After thi by the funeral or	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat			? ′es 2 □ No			
Division of Vital Records,	or Attend after death Director; # in by the f	Certification:	3 Suicide 6 Could no determine		ne, farm, street, factory, office	28	3f. Location (Stree City or Town, S	t and Number or Run State)	al Route Number,
Ω	Hospital o		200 Codding 1D/Codding	Physician: To the best of my knowle	todgo, doath coourad at the time	e date and place as	d due to the caus	e(s) and manner as	hatet
	24 ho Eun Fun	Medicai		aminer: On the basis of examination and manner stated.					
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier		29c. License			Date signed (Month,	
	118		fernand	1. J. are, in	000	041211		06/05/0	6
	17 gr		30. Name and address of person wh	no completed cause of death (Item 2	23a) (Type, Print)	Salsal	W-A	06/05/0	
	St.	ate	31. Date liled (Month, Day, Year)	8 MD 100 E C) 32. Registrar's Signatu	MUNOCC 21.	Dunspun	illa e	21801	
2	Regist		JUN 0 7	2006 Jane	4. Break				

DHMH 17 Rev 1/2001

ORIGINAL

Fernando F

igueroa	1- For State Registrar			n Black Indelible Ink of Health and Mental of Death		200	6 195	15
ysician/ xaminer	1. Decedent's Name (First	Middle,Last) Fernando	Bardales	Figueroa	2 Date of Death Month Day May 26, 2006	Year	3. Time of Death 0622 hrs	
	4a. Facility Name (if not in 250 Rockville Pik		umber)	4b. City, Town, or Location of Di Rockville		c. County of Deat Montgomery	h	
eral	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8 Date of Birth(MM		rthplace (State or Honduras	7

		Registrar												veg ivo				
Physici		1. Decedent's Nam	ie (First, Midd	lle,Last)								12	2 Date of Dea				3. Time of Death	_
edical Exami		Dav:	id Fe	erna	ando	Ba	rd	ales	$\mathbf{F}\mathbf{i}$	iguer	oa		Month May 26, 2	Day 2006	Year		0622 hrs	
		4a. Facility Name (or Location	of Death	,,		County of	Death	*	_
		250 Rockvi		on, givo c	ATOOL GITG TI	41112017				ockville					ntgom			
	4.6																	_
Funeral		5. Social Security I	Number	6. Sex		7. Age (Ir	n yrs. la	ast birthday)	_	Under 1 Ye		ler 24Hrs.	1			9 Birth	olace (State or	
Director		none		1 X M	1 2 F		21		Yrs.	flonths Da	ays Hour	s Min.	2/11	1/198	35 l	Cour	onduras	
		House Decidence	f Danadani															_
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nd Shov	F	MD	Mont	Joine	sr. À		Ga.	ither	SDU	ırg							1 Yes 2X	No
aryla Sa-f at or	당	10e Street and Nu	mber						10	f. Zip Code				10g. Citizei	n of Wha	at Countr	y?	_
e Ma or 28	Director	38 Fede	aral (70117	- -					2	0878	ı		Hor	. d			
h th 23a rotif															ndur			
eath with the Maryland items 23a or 28a-f show any nst be notified at once.	Funeral	11. Marital Status			12 Was Dee Armed F		er in U				Hispanic Ori an, Mexicar		ecify Yes or N	0- 14	 Race - White, 		an Indian, Black,	
leath r ite	Ľ.	1 Never Marri	ed 2 N	arried	1 Yes	2 X	No		1 103, 0	specify oub	an, wiexicai			.	VVIIItO,		hite	
her dan, ", or		3 Widowed	4 Di	vorced If	Yes, Give Yea			1	X Yes	s 2 N	lo specify	, поп	duras	Sp	pecify	VV	III CE	
nra min	by	15. Decedent's E	ducation (Spe		r Dates: highest gra	de comple	ted)	16a Deced	dent's U	Isual Occup	ation (Give	kind of wo	ork done	16b. Kin	nd of Busi	iness/Inc	dustry	_
hou 'naf	tec	Elementary/Sec			College (fe. DO NOT						•	
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vithi ene er th	Completed							Dan	u	cape						Сар	e Co.	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	ပိ	17. Father's Name									18.Mothe	r's Name (First, Middle,	Maiden Su	ırname)			
21; e fill tal F ked	Be	Amilca	: Baro	dale	S						Gl	oria	Figu	ieroa	ı			
213 ald b Men mar	To I	19a Informant's N	ame/Relation:	ship (Typ	e, Print)	Sis	te	r 19b. Mai	ling Ad	dress (Str			ıral Route Nu			State Z	Zip Code)	
MD 21215-0036 d.2 should be little within 72 hours after death with the Maryland that and Monda Brigele within 72 hours after death with the Maryland in 27 is marked other than "natural", or items 23a or 28a-f she anmatic event, the Medical Examiner must be notified at once	-	Leslie															d 20878	
- p # E E		20a. Method of Dis			, , ,	ucro		Place of Disp									own, State	
re, lar, Her Free Free Free Free Free Free Free		1 X Burial 2		n 2	Pomoval f	rom State	200 (crematory or	other	(Name of c	æmetery,	6/1	Pat 06					
ages nt of					Removari	on State	Ce	emete	ric	de	Sala	dito	,	RIO	Pe	rla	,Hondur	a
t P time		4 Donation 5	Other S	pecify	•			2	Name	and Addre	se of Eacily	tı				_		_
Baltimore, permit Pages I ar Department of Hee Important: If itel injury or other tr		ZI. ST. MUIE OFF	6	10	e			ĮΫ	HII	IP D	RIN	ĂLDI	FUNE	RAL	SER	VIC	E,P.A.	
у щ ап д д		Miles	of Mile	1	_				<u>241</u>	Col	<u>umbi</u>	<u>a Bl</u>	<u>vd.Si</u>	lver	Sp	rin	E,P.A. g,Md209	11
Physician		23a. Part I. Enter t failure. List or				caused the	death	. Do not ente	er the m	ode of dyin	g, such as	cardiac or	respiratory ar	rest, shock	, or hear	t	Approximate Inter- Between Onset ar	v ai
/Medical			•	0	unshot w	ounds (2) of	chest									Death	IU
Examiner		Immediate Cause or condition result			ue to (or as a											-		_
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	ᇤ	(Disease or injury		Dı.	ue to (or as a	a conseque	ence o	of)·						_		-	-	-
ed nsit	ШĂ	events resulting in	death) Last		(0. 0.0 .													
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) ce ex cian	음	UNPENDED)		AMENDED											_		
certificate be ending physicians as the burians	cian/Medical	IF FEMALE:			23c. If yes,	outcome o	of preg	nancy						23d I	Date of d	lelivery		
187 tiffic ing p as th	<u> </u>	23b. Was deceden past 12 month		he	1 Live I	birth		2	Fetal d	eath 3	B Ectop	ic pregnan	су	М	lo n th	Da	y Year	
x 6	<u> [8</u>				4 Pregi	nant at time	e of de	eath 5	Other	(Specify)								
Box e death the atter	ys	1 Yes 2	No 9 Ur	nknown	9 Unkn	iown								1				
· - > -	Physi	Part II. Other sign	ificant condi	tions c	ontributing t	o death bu	ut not r	esulting in th	e unde	rlying cause	given in P	art I.	23e. Did t	tobacco us	e contrib	ute to the	e cause of death?	_
P.O s that t gned b	b												1 Ye	s 2 1	No 3	Probal	oly 4 Unknow	า
S, I																		
cords law requi	Completed												24a Was auto				psy findings availat npletion of cause o	
CO law has	ď									_				ormed?		ath?	ilpletion of cause o	1
Re The cate	اخ												1 🗸 Yes	2 No	1	✓ Yes	2 No	
tal Rectian: The certificate ector, page	Be	25. Was case refe	rred to medic	al						26.Pla	ce of Death	(Check or	nly one)					
Vital hysician: this certif	0 B	examiner? 1 ✓ Yes	2 No	Ho	spital. 1	Inpatient	2	ER/Outpati	ent 3	DOA	Other ₄	Nursing	Home 5	Residenc	æ 6 🗸	Other S	Scene	
ing Phy ing Phy After th] ⊢	27. Manner of Dea			28a. Date	of Insurv		28b. Time	of Injury	/ 28c In	jury at Wor	k? [2	28d Describe	how injury	occurre	d		-
ding Aff	6	1 Natural		alia	FOUNT	h, Day,Year)		FOUND:	, ,				Subject sho					
Division of Vital Records, tal or Attending Physician: The law requir as after death. In Director: After this certificate has been seled in by the funeral director, page 2 should 1	ati	2 Accident		iding estigation	14			0615 hrs			Yes 2 ✓	INO						
ViS or Au ter c hirec	fic	3 Suicide		ald not be	28e Plac	ce of Injury	- At h	ome, farm, s	treet, fa	ctory, office	e building, e	etc. 2			Number	or Rura	Route Number, C	ty
Division of P pital or Attending Ph ours after death. reral Director: After t filled in by the funeral	Certification:	4 V Homicide		ermined		Found	d in n	arking lot				F	or Town, ound 250	State) Rockvill	e Pike	. Rock	ville. MD	
E G B		29a. Certifier								-1.16 17								_
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To the within 2 To the complet	ğ	one) 2 🗸	wieulcai EX		nd manner		auon a	and/or mivest	yau011,	in a riny Optilli	on, death 0	counted at	the time, date	and place	, and all	e to the t	Jause(s)	
FSFS	ž	29b. Signature and	tle of certif							29c. Lice	nse number	r		29d. Da	te signed	d (Month	n, Day, Year)	
20	1	/	1/	1						1 00	ME			May	27 200	16		

b. Signature and the or certifier	23C. Licerise Humber	23d. Date signed (Month, Day, real)
	O.C.M.E.	May 27, 2006
). Name and aduress of person who completed cause of death (Item 23a)		

Mary G. Kipple MD. 32. Registrar's Signature

2006

Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			ene 2006	19516
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Viola S. Bur	roughs				June 3		1:00 P M
	Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			Sunrise of Silve	r Spring		Silver	Spring		Montgom	ery
	Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		579-09-8691	1□M 2 X F	98 Yrs.	Worth's Days	riodis Willi.	1-22-08	Pen	nsylvania
	D.		Usual Residence of Decedent							
	how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ma	cto	Maryland Anne Ar	rundel	Annap	olis				1 X Yes 2 ☐ No
	h the	ire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	h wit	a D	5 Bristol Circle	:		21401			USA	
	deat	Jer	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Unportant: if item 27 is marked other than "natural", or items 23a or 28s-f ahow any injury or other traumatic avant, I'm Medical Examinar must be notified at anone.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 【XNo	Specify:	rican, etc.)	Black, White Specify: Whi	
ŏ	tur.	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation	11	6b. Kind of Business/Ir	ndustry
15	in 72	Completed	(Specify only highest gi	ade completed)	(Give	kind of work done of DO NOT use retired,	luring most of work)	ing		
12	than the	E	Elementary/Secondary (0-12)	College (1-4or 5		retary			Storage C	ompany
	filed Hygi ther		17. Father's Name (First, Middle, Las	t)			18. Mother's Name	e (First, Middle, M		
ylan	ould be Mental arked c	To Be	Monroe Step	henson Shi				iola Mars		
Maryland	nd 2 shoulth and 27 is my		19a. Informant's Name/Relationship Ralph S. King/ Sc			ng Address <i>(Street a</i> istol Cir			City or Town, State, Zi	o Code)
ē,	Head term	1 3	20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	1	Date 2	0c. Location - City or T	own, State
Baltimore,	ages ont of t: if i		1 XBurial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Speci			: Cemetery		06	Davidsonvi	lle. MD
Ħ	it. Puritme		21. Signature of Funeral Service Lice	**			1		alas Funer	
Ba	Depa (mpo any ir			11300					gewater, M	
	Physician /Medical Example physician and physician and stipe printing the printing that it is until the printing that it is un	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):	fulso	renally		est	Onset and Death
O. Box (iaw requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 □ Yes 2 □ H0 9 □ Unknown	d. 23c. If yes, outcome 1	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
ds, P	uires tha signed Id be de	b	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause give	en in Part I.		accoluse contribute to	/
Records,	0 5 0	Completed	Nyperte	nson				24a. Was an autopsy perform	ed? death?	opsy findings available impletion of cause of
Vital	ician: Th certificate rector, pag	Ö	25. Was case referred to medical				Of Blace of Base	1 Yes 2		2 □ No
Ξ	Physician: this certific ral director,	00	examiner?	Hospital:	оД Г Р/О	othe Othe		h Check on one		
of	Phys this ral di	<u>۲</u>	27. Manner Ceath	28a. Date of Inju		III 3 DOA	4 Mursing Ho	28d. Describe how	nce 6 Other (Speci	fy)
L	ding Phy h. After thi funeral	loi.	ratural 5 Pending	(Month, Da	y Year) Injury	Work	r? res 2 ☐ No	254. 200020	·,a.y oodanida	
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigate 3 Suicide 6 Could not	-	At home form at		20.10	20f Location (Stre	eet and Number or Rur	at Cauta Mumbas
<u>></u>	or A after Direction by	ŧ	4 Homicide determined	building, et	ury - At home, farm, st c. <i>(Specify)</i>	reet, lactory, office		City or Town,		ar noble ivoliber,
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	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai			f examination and/or in				use(s) and manner as a te and place, and due to	
	ompl	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month,	Day, Year)
	->-0		· Anon			C	-611.	7	6151	26
			30 Name and address of	completed acres of	leath (Item 22c) (Tree-	Print) NT-	200 7	MD	0/2/1	
			30. Name and address of person who				een Kango	, M.D.	ł I	
			7610 Carroll Ave	., Takoma 32. segistr	Park, MD 20 ar's Signature	1912				
	Sta Registi		31. Date filed (Month Day Year)	2006	. K A	mark a				

			1 - For State Registrar	State of Marylar	nd / Depa	artment of F rtificate of	Death	R	eg. No.	16 1951
	Physici /Medic		1. Decedent's Name (First, Middle, La Robert Blair	Brown, Jr.		_		2. Date of Dear Month June 2	, ^{Day} 2006	ar 3. Time of Death 6:00 P M
	Examir Funeral Director	ner	4a. Facility Name (If not institution, given 218 Harbor Lane 5. Social Security Number 6. Security Number 6	Sex 7. Age (In yrs.	last birthday) Yrs.	4b. City, Town, of Queensto	r Location of Deat WN If Under 24 Hrs Hours Min.		Queen (Year) 943	
	ס	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Queen A	10c. Ci	ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	uth with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 218 Harbor Lane			10f. Zip Code 21658	3	1	0g. Citizen of Wha	at Country?
020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Dependence of Heatih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-f show eny injury or other treumstic event. The Medical Examinar must be notified at once.	by	11, Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates: 1961		Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		American Indian, White, etc. White
7-61717	d within 72 ho piene. r than "natu the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th		(Give	dent's Usual Occup kind of work done DO NOT use retired Urance Ac	during most of words)	rking	16b. Kind of Busin	
אומוות י	ould be filed Mental Hyg arked othe atic event.	To Be C	17. Father's Name (First, Middle, Last Robert Blair	Brown, Sr.			18. Mother's Nar Laur	ne (First, Middle, M rette Par	Maiden Sumame) is	
C, Ma	1 and 2 sho Health and em 27 is m ther treum		19a. Informant's Name/Relationship (Ronald B. Brown/ 20a. Method of Disposition	Son	316	ng Address (Street Dawnwood strion (Name of	Drive. E	dgewater		37
	nit. Peges entment of l ortant: If it injury or o		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service)	(y) Re	surrec	sition (Name of matory or other place tion Cemes 2. Name and Addre	etery 6-6	-06	Clinton,	
2	Depermine Deperm		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deal	2	973 Solon	ons Isla	nd Rd. E	dgewater	, MD 21037 Approximate Interval Between
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or as a consect.) Due to (or as a consect.)		Coron	ary Ar	tery Di	Soase	Onset and Death 30 Yes
,00700	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	dicai Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consec	quence of):					
.O. DOA	the death certifi by the ettending ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnative birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms of the second s	uldeath 3□	Ectopic pregnancy Other (specify)	,		23d. Date o Month	f delivery Day Year
, 23,	equires tha sen signed l	by	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob		ite to the cause of death? Probably 4 Unknown
מו וופר	n: The law r ificate has bu or, page 2 sh	e Completed	25. Was case referred to medical					24a. Was ar autops perform 1 Yes 2	y prio ned? dea XX No 1 □	e autopsy findings available r to completion of cause of th? Yes 2 \(\sumbolea\) No
5 15 15 15 15 15 15 15 15 15 15 15 15 15	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours afterders. The the Funestell Directors After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use a.	70 B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing H	ome 5 Reside 28d. Describe ho	nce 6 Other (Specify)
2	pital or Attures after de seal Directo	i Certification:	3 Suicide 6 Could not b	building, etc. (Specif	(y) 			City or Town	, State)	or Rural Route Number,
	ro the Hos vithin 24 ho ro the Fund completely f	Medicai	29a. Certifier 1 Certifying Pt (Check only one) 29b. Signature and atte of certifier	nysician: To the best of my knommer: On the basis of examina and manner stated.	ation and/or in	occurred at the tin vestigation, in my o	pinion, death occu	rred at the time, da	ate and place, and Odd Date signed (N	due to the cause(s)
	. > - 0		30. Name and address of person wto	commeted cause of death (Iter	n 23a) (Type,	Print)	05037	<u>-1</u>	06/03	/2006 lis 21401
	Sta Registr		Thomas F. Hat 31. Date filed (Month, Day, Year) JUN 0 6	7006 32. Figistrar's Signa	9 Tig	le wate	r Colon	y Drive	Annapo	[is 2140]

			For State Registrar	State of I	<i>l</i> larylar	nd / Depa <i>Cei</i>	artmer rtifica	nt of H te of L	ealth a D <i>eath</i>	and M	lental H	ygier Reg.		6	19518
	ý		1. Decedent's Name (First, Middle, La	st)							2. Date of I		Day Ye	ar	3. Time of Death
	Physici		Mable Lee Bracey								Month May		2006 '	ai	4:00A M
}	/Medio Examin		4a. Fecility Name (If not institution, giv	street and number	or)		4b. City	Town, or	Location of	of Death			4c. County of	Death	
		7	5024 Adrian Stree	t			Ro	ckvi.	11e,						
	Funeral		Social Security Number 6. S	ex 7 □M 2□ X F	Age (In yrs. 83	last birthday)		r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month,	Dav. Ye.	ar)	Count	ace (State or Foreign
	Director		230-28-2285	_ W 2CA	0.5	Yrs.					Oct.	23,	1922 \	irg	inia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City Limits
	Aaryti Feho	ō	Maryland Montgon	arv	Pool	kville									1 X Yes 2 □ No
	ith the Marylan or 28a-f ehow a notified at	Director	10e. Street and Number	<u> </u>	ROCI	KVIIIE	10f. Zi	p Code				10g.	Citizen of Wha	t Count	ry?
	Mith Ba or		5024 Adrian Stree	t								IJ	nited S	tat	es
	within 72 hours after death with the Maryland ene. than 'naturel', or iteme 23e or 28e-f ehow ha Madical Exemiter must be notified at	Funerai	11. Marital Status	12. Was Decede		I.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or I		14. Race -	America	an Indian,
ဟ	or ite	교	1 Never Married 2 Married	Amed Force 1 Tes 2 If Yes, Give			lf Yes, spe 1 □ Yes				Rican, etc.)		Black, 1		
ğ	rei', c	þ	3 X Widowed 4 ☐ Divorced	Year or Date	s:		1 LI Yes	2EN NO	Specify:				Specify:	B1a	ck
21215-0036	natu Ical	Completed by	15. Decedent's Education (Specify only highest gra	ducation		16a. Dece	dent's Usu	al Occupa	ation during mos.	t of worki	na	16b	. Kind of Busin	ess/Ind	ustry
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	lygier her th		12th.			Laur	ndry	Serv		arta Maria	/First Adida		Private		
ng	be fit d off	Be	17. Father's Name (First, Middle, Last,	1								ие, мак	len Sumame)		
3	2 should be filed within 72 hours after dea and Mental Hygiene. is marked other than "naturel", or Iteme 'aumatic event, Iha Madical Exeminator	ို	Wesley Rainey 19a. Informant's Name/Relationship (T 0-i		105 14:45	- 4 4 4	- (0		lley		ans	y or Town, Sta	t- 7:-	Cordo
Maryland	d 2 st th and 7 is n traun		Ann Mackey/Daught												Code)
	1 and Health em 27 ther to		20a. Method of Disposition		20b. I	Place of Dispo	sition (Na	me of	1	, Ro	CKVILI Date	e 1	Marylan Location - Cit	d y or To	wn, State
Jou	Pages nent of ury or o		1 Burial 2 Cremation 3			cemetery, creater than the company of the company o				06/03	3/2006	Wh	eaton.	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or iteme 23a or 28a-1 ehow importent: if item 27 is marked other than "batcal Exeminar must be notified at any follow or other traumatic event, the Madical Exeminar must be notified at any lours.		4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Lices					_	1				neral H	ome	
Ba	Departr Import eny Inj		1/alish m	(leams)							•				DC20011
			23a. Part1. Enter the disease, or com	plications that cau	ed the deat								.Diring C	JII,	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final			ry Art	0 237]	liana							Onset and Death yrs.
	/Medical		disease or condition resulting in death)	α	as a consec	_ -	ery i	JISCA	.50						, y13.
	Examiner		Constant the first conditions	b											
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consec	quence of):									
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8760,	ate be ex hysician a the burial	<u> </u>	Todating in douting basis	Due to (or	as a consec	quence or):									
87	physics the t	dicai	•	d											
9 ×	eath certific attending p I for use as t	Physician/Me	IF FEMALE:	23c. If yes, outcor	ne of pregn	ancv							23d. Date o	f dollar	
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	al death 3	Ectopic p	regnancy					Month		Day Year
o.	that the ded by the detached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknow			_	pooy/				_			
Δ.	res that igned b be deta		Part II. Other significant conditions	ontributing to deat	but not res	sulting in the u	nderlying	cause give	en in Part I		23e. Di	d tobacc	o use contribu	te to th	e cause of death?
rds	n sign	d by	Chronic 0	bstructiv	e Pul	monary	Dis	ease			1[⊒ Yes	2⊠No 3[Proba	ably 4 Unknown
Ö	w requires been si	jete									24a. W		24b. Wei	e autop	sy findings available
of Vital Records,	The law sete has b page 2 st	Completed									pe	topsy normed 20	? dea	th?	pletion of cause of
ta		BeC	25. Was case referred to medical				-		26. Place	of Death	1 Check onl		NO TO	105	20 100
<u>></u>	Physician: this certificral director,	ToB	examiner? 1 ☐ Yes 2 ∑ No	Hospital: 1 ☐ Inp	atient 2	ER/Outpaties	nt 3 D	OA Othe					6 □Other (Specify)
0	ng Ph ter th		27. Manner of Death	28a. Date of I (Month,	njury Day Year)	28b. Time o	f	28c, Injun Work	at		28d. Describ	e how in	njury occurred		
Θ	Attending r death. sctor: After oy the fune	atic	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigatio	n			М		Yes 2□	No					
Division	or Att	Certification:	3 Suicide 6 Could not be determined	289. Place of	Injury - At h etc. (Speci	iome, farm, st	reet, facto	ry, office				(Street Town, St		r Rural	Route Number,
	Hosp 4 hou Fune fely fi	edicai	(Check only 2 Medical Exam	nysician: To the be miner: On the basi	of examina										
	To the Hospital within 24 hours (To the Funeral) completely filled	Med	one) 29b. Signature and title of continuo	andmanner	stated.		20	c. License	number			29d	Date signed (A	Nonth (Dav. Year)
			2 4	Va	//								/30/200		,,, /
	7		30 Name and 1	well	Neck	m 23a\ /T		D098	J4			0.5	, 50, 200	, 0	
			30. Name and address of person who Dr. Barry Rosenba					Kene	inoto	n N	farv1 o	nd o	ი795		
	Sta	ite	31. Date filed (Month, Day, Year)	32 /R eg	strar's Signa			_	TIISCC	7119 F.	агута	iiu Z	0/33		
	Registi		JUN 7 2	006	1421 1	15 M	we	(6)							

			For State Registrar		Sta	ate of N	Maryland	-	rtment tificate					Reg. No	4 U L	6	19519
	Dhysisi		1. Decedent's Name (First, Mide	ile, Las	t)								Date of De Month	eath Da	у `	f ear	3. Time of Death
	Physici /Medio		Ambre			ade		3rown					une 6		006		5:25 aM
3	Examir		4a. Facility Name (If not instituti	-							Location of	of Death			. County of		
			253 West M	-						Elk		0411			Ceci		
	Funeral		5. Social Security Number	6. Se	ox □M 2		Age (In yrs. la	i <i>st birthd</i> ay) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Di ug • 1	rth ay Year)	000	Cour	lace (State or Foreign htry)
	Director		221-76-8355				22	Trs.				A	ug. 1	. 2 , 1	983	ner	äware
	P		Usual Residence of Decedent 10a. State 10b. Count	v			10c. City,	Town or Lo	cation							1	0d. Inside City Limits
	aryler et e	5						D11-4									1 XYes 2 No
	death with the Marylend me 23e or 28e-f ehow rmust be notified at	Funeral Director	MD Ce 10e. Street and Number	<u>cil</u>				Elkt	10f. Zip	Code				10a Cit	izen of Wh	at Cour	ntry?
	with a second	늅							Tot. Zip		001						,
	e 23	era	253 West Mai	n_5			nt Ever in U.S	13 \	Vas Deced		921 spanic Ori	gin? (Spec	ify Yes or No) ·	USA 14. Race		en Indian.
	Iten d	چ	1 Never Married 2 Ma	rried	An	med Forces	s?		Yes, spec	ify Cuba	n, Mexicar	, Puerto R	ify Yes or No ican, etc.)			White,	
36	hours after ture!, or ite at Exemine	P.	3 ☐ Widowed 4 ☐ Divorce		11.7	Yes, Give			I□ Yes 2	No CX	Specify:				Specify:	Wh	ite
21215-0036	72 hours neturel',	8	15. Decede	nt's Ed	ucation			16a. Deced	lent's Usua	I Occupa	ition			16b. K	ind of Bus	ness/In	dustry
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	2 should be flied v n and Mental Hygie 'le marked other t reumetic event, ID	Bec	17. Father's Name (First, Middle	, Last)								r's Name	(First, Middle				
Maryland	d be ental	To B	David Brown								Su	zann	e Kor	tve	lesv		
<u> </u>	mit. Pages 1 and 2 should sartment of Health and Men ortent: if Item 27 ie marke injury or other treumetic is.	-	19a. Informant's Name/Relation	iship (7	уре, Рг	rint)		19b. Mailin	g Address	(Street a			Route Numb			tate, Zip	Code)
M	od 2 in all the all th		Suzanne Br	own	1			253	West	Ma	in S	troo	t, El	kto	n v	5	21921
ā,	Head the		20a. Method of Disposition	<u> </u>			20b. Pla	ace of Disno	sition (Nam	ne of		Da			ocation - C		
<u>ē</u>	ages nt of t: H i		1 Burial 2 Cremation			al from Stat	Θ	metery, cren				T	7 06		F7		
Baltimore,	it. Purtue		* 4 Donation 5 Other			co	442	tomy	. Name and				7,06				, MD
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			23a. Part1. Enter the disease,	7	lication	e that caus	at the death								walk	, D	Approximate Interval Between
	Medical Examiner prijaristransit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b	Due to (or a	as a consequence a consequence a consequence a consequence a consequence as a consequence a	ence of):	na_								Onset and Death
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89														- 7			
.O. Box	iew requires that the death certifics ss been signed by the attending pt 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√□No 9 □ Unknown		1(4(Live birth	ne of pregnan 2 Fetal at time of dea	death 3□	Ectopic pro						23d. Date Monti		ory Day Year
Δ.	ires that signed b	<u>م</u>	Part II. Other significant condi	tions co	ontribut	ing to death	but not resul	lting in the ur	nderlying ca	ause give	ın in Part I.						ne cause of death?
Ö	w requir been si shouid	e e											24- 145-		045.144		
Division of Vital Records,	The ete h	Completed											24a. Was auto perfo 1 Yes	psy ormed?	pri de	or to co ath?	psy findings available mpletion of cause of 2 No
<u> </u>	icien: ' certifice ector. p	å	25. Was case referred to medic examiner?		Hospita	al-				Otha			(Check only	_		_	
5	Physicien: this certific ral director.	၉	1 ☐ Yes 2 ☐ No			ı∟ınpa		R/Outpatien					e 5 Res				()
Ĕ	a te	on:	27. Manner of Death 1\□Matural 5 □ Pend	ling		a. Date of In (Month, E	Day Year)	28b. Time of Injury		8c. Injury Work			3d. Describe	now injui	ry occurred		
Sio	death. death. ctor: A y the fu	cat	2 Accident inves 3 Suicide 6 Coul	tigation					М		/es 2 □						
∑	or Att	Certification;	4 Homicide deter	mined	286	 Place of I building, 	njury - At hor etc. (Specify)	ne, farm, str	eet, factory	, office		28	If. Location (City or To			or Rura	l Route Number,
	To the Hospital or Attentwith 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Ph	niner: O	: To the bes		rledge, death on and/or inv	occurred a	at the tim in my op	e, date an inion, dea	d place, ar th occurre	nd due to the d at the time,	cause(s)	and manr f place, an	ner as si d due to	ated. the cause(s)
	To the within To the compl	Ψ.	29b. Signature and title of certif	ier							number	0,		29d. Da	te signed (Month,	Day, Year)
			- Kl	att	2					U 5	408	20			June	7.	2006
			30. Name and address of person	n who	complet	ed cause o	death (Item	23а) (Туре,	Print)								
	5		J. Knatri,	ΜĐ	_	111 7	West	High	Stre	et,	#10	4, E	lktor	1, M	D 21	921	
	Sta		31. Date filed (Month, Day, Yea	r)			strar's Signate										
4	Registi	ar	JUN	Q	2008		Rue	10 1									

State of Maryland / Department of Health and Mental Hygiene 19520 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month William Stanton Burton June 2006 1:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Montgomery Bethesda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 28, 19 5. Social Security Number 6. Sex 12 M 2 ☐ F 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Director 577-05-4008 89 Yrs 1916 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 le marked other then "neturel", or iteme 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Maryland | Montgomery Bethesda Directo 1 ☐ Yes 2X No 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 9413 Corsica Drive 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 1\(\hbar\) Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Ā 1 ☐ Yes 2 ☐ No Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Meat Broker Wholesale Meat and Mental Hygid 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental H tent: If item 27 is marked out 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Stanton Herbert Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel E. Burton/Wife 9413 Corsica Drive, Bethesda, MD 20814 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö Department of Importent: If eny Injury or QUCE. June 7, Charlotte Hall, MD Brinsfield-Echols Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee 62 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner h Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Examine ed by the attending physician and detached for use as the burial-transit c. Coronary Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death Dav Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: certificate Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No : After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٢ ō 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division or Attending 1X Natural 5 Pending investigation Injury after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital within 24 hours after de To the Funeral Direct 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 2. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Osmu JUINNO D0047330 June 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas V. Joseph, M.D. 50 W. Edmondston Dr. Suite 207 Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State JUN 0 8 2008 Registrar

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State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 6:45 а м Geraldine Marie Brooks May /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Arnold Futurecare Chesapeake If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 79 220-20-8773 May 27, Director 1927 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23s or 28s-f show other treumstic event, the Madical Examinar must be notified at MD Anne Arundel Annapolis 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1084 River Bay Road 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iter eny injury or other treumatic event, the Medical Exemplical ORE. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cottege (1-4or 5+) Secretary Law Firm 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Oliver John Bell Helen Marie Zwanzger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oliver R. Bell/Brother 1084 River Bay Road Annapolis, MD 21401 June 2, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Johns Cemetery 2006 4 ☐ Donation 5 ☐ Other (Specify) Parkville, MD 21. Signature of Juperal Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 yours Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** brovas 10 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnar 23d. Date of delivery in the past 12 mon 3 Ectopic pregnancy ò Month Year 4 Pregnant at time of death 5 Other (specify) detached مناه nas been signed by ا page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Donknown 3 Probably 1 ☐ Yes 2 ☐ No Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 \[Yes \] 2 \[No \] 24a. Was an autopsy performer 1 Tes 2 No To the Hospitel or Attending Physicien: funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Oeath (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 3 No 1 Yes 3□ DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred Medical Certification: After 1 Diatural 5 Pending 1 Tyes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident illed in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier ans Hwy M. Uersville Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 19523

		1- For State Registrar		Ce	rtificate o	f Death			Reg No	400	0 1702
Physici	an/	1. Decedent's Name (First, Midd	lle,Last)					2. Date of	Death		3. Time of Death
Medical Exam	iner	Kevin Michael	Beares					June 1	3, 2006	Year	1626 hrs
		4a. Facility Name (if not institution		nber)		4b. City, Town,	or Location of	Death	4c. Cou	nty of Death	1
		319 Millwright Circle				Abingdon			Harfo	rd	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Under:	24Hrs. 8. Date o	f Birth(MM/DD/Y		thplace (State or
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Hyg Hoth		17. Father's Name (First, Middle,	, Last)				18.Mother's	Name (First, Midd	le, Maiden Surna	me)	
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Vital Rec ysician: The l his certificate l	Be (25. Was case referred to medical examiner?				26.Plac	e of Death (Ch	neck only one)			
Vit hysic this c	To E	1 ✓ Yes 2 No	Hospital: 1 Inp	patient 2	ER/Outpatient	3 DOA	Other N	lursing Home 5	Residence 6	Other	Scene
ing Ph After 1		27. Manner of Death	28a. Date of	Injury	28b. Time of Ir	njury 28c. Inj	ury at Work?		e how injury occ	urred	
ion tendi eath or: /	읥	1 Natural 5 Pend			FOUND: 1617 hrs	1	Yes 2 🗸 No	Subject s	not seit		
/iSi r Att ter de irect n by	<u>[2</u>]		Juli de la constantia del constantia del constantia del constantia del constantia del const		ome, farm, stree	t, factory, office	building, etc.	28f. Locatio	n (Street and Nur	mber or Rur	al Route Number, City
Divis pital or At ours after d eral Direc	Certification:		market and the	Single Fan	nily			or Towr 319 Millw	i, State) right Circle, A	Abinadon	MD
Hospi 4 hou Fune ely fi		20a Cartifica	nysician: To the best of			ed at the time of	late and place				
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certwin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for use	edical	(Check only one) 2 ✓ Medical Exam	miner:On the basis of	examination a	nd/or investigati	on, in my opinio	n, death occur	red at the time, da	ite and place, an	d due to the	cause(s)
To To	ě	29b. Signature and title of certifie	and manner sta	ted		29c. Licen	se number		29d Date si	aned (Man	th, Day, Year)
_	-	QUAD	*				.M.E.				in, Day, rear)
		unesz					.1₹1. ⊑.		June 14,	2000	
	1	30. Name and address of person			•	track D. III		204		- L-1911	
7			sistant Medical Ex		111 Penn S	ueet, Baitim	ore, IVID 21	IZU I			
ॢ St Regis	ate	31. Date filed (Month Day, Year)	2006 32. Regi	istrar's Signati	N A	100					
			1	Stort 1	A. Park		-		<u> </u>		
DHMH 17 Rev 1/2	UU1				ORIĞINAL	_					

			1 - For State Registrar	State	of Marylar		artment of I				ene	2008	1952
			1. Decedent's Name (First, Middle	le, Last)	 					2. Date of Death	1		3. Time of Death
	Physici /Medio		Ruth		B1c	omfiel	đ			Month June	Day 4	Year 2006	11:04 A M
)	Examir		4a. Fecility Name (If not institution	n, give street and n			4b. City, Town,	or Location o		June		ounty of Deat	
			10500 Rockvill	e Pike #1	1201		Rockv	ille			Mo	ntgome	rv
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,	Vear)	9. Birti	nplace (State or Foreign
	Director		017-22-3822	1 □ M 2 X) F	9)1 Yrs.	World Days	riours		Aug 2. 1			many
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	nation						404 1
	aho aho	č	MD Montg			Rockvi							10d. Inside City Limits XXYes 2 ☐ No
	28s-1	Director	10e. Street and Number			TOCKVI.	10f. Zip Code			40	0''		
	Vith of the	ā		- D41- /	41001							on of What Co	,
	ns 23	Funeral	10500 Rockvill 11. Marital Status		Cedent Ever in U	IS 13 1	20852	Hispanic Orio	nin? (Spec	Un		d State . Race - Amer	
	fter d	Fun	1 ☐ Never Married 2 📉 Mar	Armed F	orces?	,	Was Decedent of If Yes, specify Cub	an, Mexican	, Puerto R	ican, etc.)	, ,	Black, White	etc.
ğ	urs a	ρχ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	Z∕XNo live Dates:		1□Yes 21XNo	Specify:			S	pecity: Wh	nite
21215-0036	filed within 72 hours after death with the Maryland Hygione. that than "natural", or itams 23a or 28s-f ahow that the Medical Examiner must be notified at	Completed		t's Education		16a. Dece	dent's Usual Occu	pation		10	6b. Kind	of Business/I	ndustry
21	thin 7	ple	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done DO NOT use retire	during most ed)	t of working	9			,
2	gien gien arth	Con	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2		Home	emaker				Но	me	
פ	be file htal Hy od oth	Be (17. Father's Name (First, Middle,	•				18. Mothe	r's Name ((First, Middle, Ma	aiden S	umame)	
<u> </u>	should the many marked in	To I	William Marcus	5				Ţ	Unkno	wn			
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Merial Hygiene 1 status!, or items 23a or 28s-f show fitting 71 is marked other than "natural", or items 23a or 28s-f show other traumetic event, The Madical Examiner must be notified at		19a. Informant's Name/Relations				ng Address (Street						
	and ealth m 27		Alexander Bloom	field / H			Rockvill	le Pk.	#120	1 Rockv	ille	e, MD 2	.0852
Baltimore,	of H if ita		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □ Bernoval from		Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)	Da	te 20	0c. Loca	tion - City or 1	Town, State
Ē	permit. Pages 1 Department of H Important: If its any injury or ott		4 ☐ Donation 5 ☐ Other (S				Cremato	- 9	6-8-0	T	a11s	Churc	h. VA
3a I	epart oport ny in		21. Signature of Funeral Service	Licensee		22	. Name and Addre	ess of Facility	Jose	ph Gawl	er's	Sons	Inc.
	₫0 = e d		23a. Part1. Enter the disease, or				130 Wisco					on DC	20016
ř	Physician physician and Medical Examiner but steep private and ste	Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aA1z] Due to b Due to	heimer so (or as a consection as a consection (or as a consection as a consect	s Disea quence of): quence of):							Approximate Interval Between Onset and Death
	es that the death certificate be igned by the attending physicia be detached for use as the bur	an/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 ☐ Feta nant at time of d	aldeath 3	Ectopic pregnanc	y			230	d. Date of delik Month	very Day Year
	the cay the achec	Physici	1 Yes 2 No 9 Unknown	9□ Unkr			(0,2-0)/						
Records, P	.≘ თუ	ρ	Part II. Other significant condition	ons contributing to c	death but not res	ulting in the un	nderlying cause giv	en in Part I.		23e. Did toba			the cause of death?
S S	aw asb	Completed								24a. Was an	2	24b. Were aut	opsy findings available ompletion of cause of
	0 - 0	E								autopsy performe	ed?	death?	
Altai Vitai	sician: Th certificata rector, pag	Bec	25. Was case referred to medical					26. Place	of Death (1 ☐ Yes 25 Check only one	Ž INO	10 105	2 NO
<u> </u>	Physician: this certific ral director,	일	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	1 3□ DOA O#			9 5 Residence	ce 6[Other (Speci	fv)
	ding P. h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	28c. Injur	y at		d. Describe how			·//
9	Attending r death. ector: After y the fune	atle	2 Accident investig	ation	,	,,		Yes 2 □ N	lo				
		Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place	e of Injury - At he ling, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office		28	f. Location (Stree City or Town, S	et and N State)	lumber or Run	al Route Number,
:	the Hospital or hin 24 hours efte the Funerel Dir npletely filled in	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician : To the E xaminer : On the b and man	e best of my kno pasis of examina iner stated.	wledge, death tion and/or inv	occurred at the tir restigation, in my o	ne, date and pinion, death	l place, and n occurred	d due to the caus at the time, date	se(s) an	d manner as s ace, and due t	stated. o the cause(s)
	To t	Σ	29b. Signature and title of certifier				29c. Licens	e number		29d	l. Date s	igned (Month,	Day, Year)
	14		1010	Luc	12	20	D26	259		J	une	5,2006	5
	1		30. Name and address of person					_					
			Ava Kaufman MD	9.2-(2)			U2 Bethe	sda, M	ш 208	314			
	Star Registr		31. Date filed (Month, Day, Year)	2006	Registrar's Signa	trure	the s						

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certif	icate of	Death			Re	eg. No.	UU	0 190) (
Physici Medical Exam		1. Decedent's Name (First, Mide		BOWLES					Date of Dea Month May 16, 2	th Day Yea		3. Time of Death 1520 hrs	
		4a. Facility Name (if not instituti 3358 Toledo Terrace	on, give street and n		44	City, Town, o				4c. County of		's	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Ye	ear If Unde	er 24Hrs.	8. Date of Bir	th(MM/DD/YYYY			
Director		577-66-6425	1 M 2 F	61	Yrs.	Months Da	_	Min.		2, 1944	Foreign		С.
è		Usual Residence of Decedent 10a. State 10b. County		10c. City. To	un or Locatio								
1 Icow an												10d. Inside City Lin	
Maryland 28a-f show any d at once.	ctor	MD. PRINC	E GEORGES			ATTSVI	LLE		- 14	0.01		1 Yes 2	NO
ne Ma or 28	Director		TEND LOD	11 ***		·			11	0g. Citizen of Wh		•	
with the s 23a		3358 TOLEDO		#K.	13 Was	20 Decedent of H	782	nin2 / Spec	ify Ves or No		S.A.	an Indian, Black,	
Baltimore, MD 21215-0036 Pentil: Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoinjury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 X Never Married 2 N	larried Armed F			, specify Cuba				White		an Indian, Black,	
after o	by F	3 Widowed 4 Di	vorced If Yes, Give Ye		1 1	es 2 X N	o specify:			Specify:	BLAC	CK	
hours natur Cxami	ed t	15. Decedent's Education (Spe	ecify only highest gra		a. Decedent's	Usual Occupation	ation (Give	kind of wor	k done	16b. Kind of Bu			
36 in 72 han "	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)				use remed	.,			_	
5-0036 iled within 7 Hygiene.	Completed	12 17. Father's Name (First, Middle	Last)		M	AIL CLI		e Nama (E	ient Middle A	FED Maiden Surname)	. GC	V'T.	
215 be file ntal Hy rked o	Be C	WILLIAM	,	OWLES			TO.MOUTO	,	LINE		MITH	T	
21 ould b d Men s mar tic eve	Το	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing A	ddress (Stre	et and Num	ber or Rur	al Route Num	ber, City or Towr	n, State,	Zip Code)	_
MD nd 2 sho alth and m 27 is	7.0	WILMA B. JE	NKINS/SIS		124 C	OTTSFO	RD DR.	SW,	ATLAN	ΓA, GA.	3033	31	
or Hez		20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Removal fi	om State 20b. Plac	e of Disposition atory or othe	on (Name of co	emetery,		Date	20c. Location -	City or T	own, State	
Baltimore, sernit. Pages I ar Department of Hes important: If ite njury or other tr		4 Donation 5 Other S	pecify:		BERS C	REMATOR	RY	6-2-2	2006	RIVERD	ALE,	MD.	
Balt Depart		21. Signature of Funeral Service		17 2000	22. Na CHA	ne and Addres MBERS E	s of Facility UNERA	L HON	1E & CI	REMATORI	UM.P	. A.	
Physician		23a. Part I. Enter the disease, or	complications that of	aused the death Do	91 580.	L CLEVE	ELAND	AVE.	RIVE	RDALE, M	D. 2	0737	
/Medical		railule, List offly offe cause	on each line.	rotic Cardiovaso			9, 30011 03 00	ardiac or re	sopilatory arre	st, shock, or nea	11	Approximate Interv Between Onset ar Death	
Examiner	ì	Immediate Cause (Final disease or condition resulting in death)		consequence of):	ulai Disea								_
	<u>.</u>	Sequentially list conditions,	b										
	nine	if any, leading to immediate Cala Enter Industry & Cause (Disease or injury that initiated		a consequence of):									
ted nsit	Examiner	events resulting in death) Last	,	consequence of):							\neg		
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed r death ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	n/Medical	UNPENDED	d AMENDED			 ,			<u>-</u>				
8760, tificate be exeng physician as the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in ti		outcome of pregnanc						23d. Date of d	delivery		
certification of the control of the	cian	past 12 months?	I LIVE L	oirth nant at time of death	2 Fetal		Ectopic	pregnancy	′	Month	Da	y Year	ı
Box e death of the atten	Physicia	1 Yes 2 No 9 Un	known 9 Unknown		5 Othe	(Specify)							
P.O. Box 68 that the death certi med by the attendin		Part II. Other significant condit	ions contributing to	death but not result	ing in the und	erlying cause	given in Par	rt I.	23e. Did to	pacco use contrib	oute to the	e cause of death?	
S, P. uires th	Completed by								1 Yes	2 No 3	Probab	bly 4 🗸 Unknown	1
ord aw req as bee	plet								24a. Was a autops		ere autorior to cor	psy findings availab npletion of cause of	ole f
Rec The Iz cate h	E O								perform 1 ✓ Yes 2	ned? de	eath?	2 No	
tal Recting	Be	25. Was case referred to medica examiner?				26. Place	e of Death (Check only	one)				_
of Vital Records, ng Physician: The law require When this certificate has been si meral director, page 2 should b	٥	1 ✓ Yes 2 No 27. Manner of Death			Outpatient 3			Nursing H		Residence 6		cene	
on of or and on of the or and or	Certification:	1 V Natural 5 Pend		, Day, Year)	. Time of Inju		ıry at Work? Yes 2 🔲 I		d Describe ho	ow injury occurred	đ		
Division tal or Attendir 15 after death al Director: A	icat	2 Accident Inve	stigation 28e Plac	e of Injury - At home,	farm street				Location (St	treet and Number	or Buse	Route Number, Cit	
Divi	er <u>i</u>		d not be (Specify)	, , , , , , , , , , , , , , , , , , , ,	,	201019; 0111001	odildirig, cto		or Town, Sta	ate)	or Rurai	Route Number, Cit	.у
Hos 24 h Fun		20e Cortifies	nysician: To the bes	t of my knowledge, d	eath occurred	at the time, d	ate and place	ce, and due	e to the cause	(s) and manner a	s started	1	\dashv
D To the Hospital within 24 hours To the Funeral completely filled	edical	one) 2 Medical Exa	miner: On the basis of and manner s	of examination and/or	r investigation	, in my opinior	n, death occ	urred at the	e time, date a	nd place, and du	e to the c	ause(s)	
- /	ž	29b. Signature and title of certifie	10			29c. Licens				29d Date signed	(Month	, Day, Year)	ヿ
φ		Cahalla	12/	7		O.C.	M.E.			May 17, 200	6		
		30. Name and address of person Zabiullah Ali, M.D.	who completed caus Assistant Medic			Street, Balt	imore M	ID 2120-	1				\exists
St	ate	31 Date filed (Mp) Pay, Year)	120.6	gistrar's Signature			e, IVI	2120					\dashv
Regist	rar	JUN B		Bur B.	Specie	J							

State of Maryland / Department of Health and Mental Hygiene 0 6 19526 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** Bradyhouse Anna June 3, 2006 5:40 /Medical 4b. City, Town, or Location of Death 4c. County of Death As Escility Name (If not institution, give street and number, Examiner (avoll Summerville Westminst If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Davs 1 □ M 2X0 F Hours 220-14-8144 79 04-21-1927 Director MD Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County r then "naturel", or items 23a or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 USA 17901 Gunpowder Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: if item 27 is marked other then "I any injury or other traumatic event, Its Mag pages. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick L. Helen M. Myers Harmyer ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2904 Lawndale Rd., Finksburg, MD 21048 Joyce Blanche Little -Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Hampstead Cemetery 06-16-2006 Hampstead, MD 21, Sign (u)e Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home clana MO0550 934 S. Main St., Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 140(2/01/2 Physician YUGN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à 1 TYAS 2 NO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 hes autopsy performed certificete 1 Yes 2 🗹 No director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital:

☐ Inpatient Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA this To the Funeral Director: After the completely filled in by the funeral 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after Jo the Funeral Dire 4 Homicide 1 artifying Physician: To the basis of my knowledge, death occurred at the time, date and does and due to the causa(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number 00059943 une 13,2000 30. Name and address of corson who completed cause of death (Item 23a) (Type, Print) Stoner Are. Svik 307 295 MON 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JUN 15** 2006 Registrar

			1 - For State Registrar	State of Mar		artment o			iene 20 (06 19527
	Physicia /Medic		Decedent's Name (First, Middle, Last) Hyder Edward B	Barr				2. Date of Death Month June		3. Time of Death 8:49p M
	Examin		4a. Facility Name (If not institution, give s Copper Ridge 5. Social Security Number 6. Sex		(In yrs. last birthday)	, ·	n, or Location of Death SV $i11$ e sar \mid If Under 24 Hrs		4c. County of	1
	Funeral Director			M 2□F 91	Yrs.	Months Da			Year) 1915	Birthplace (State or Foreign Country)
	Ba-f ehow	Director	MD Baltimore		10c. City, Town or Lo Reiste	erstown				10d. Inside City Limits 1 ☐ Yes 2 ☐ Who
	e 23a or 2		10e. Street and Number 1010 Green Hill Fa	arm Road	or in H.C. 12.1	10f. Zip Cod 211	36		USA	at Country? American Indian,
020	ours efter de al', or item Exandment	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates:	T.T./T.T	rvas Decedent f Yes, specify (1 ☐ Yes 2 ☐	of Hispanic Origin? (S cuban, Mexican, Puer No <i>Specify:</i>	to Rican, etc.)		White, etc.
0-0-1	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Heath and Mental Hygiene. Deperment of Heath and Mental Hygiene. Important: If time X7 is marked other then "natural" or iteme 23e or 28e-f ehow any injury or other traumatic event, the Mudical Exactions could be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	_	ccupation one during most of wo tired) Manager	rking	Gulf Oil	
מוומ ע	uld be filed Aental Hygir rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Hyder Edward Barr	-			18. Mother's Na	me (First, Middle, N Weaver		
, mary	and 2 shore		19a. Informant's Name/Relationship (Type Pamela Lichty (daug		1010	Green 1		Rd., Reis	terstown	n, Md 21136
	Pages 1 tment of H tent: If ite		20a. Method of Disposition 1 Bunal 2 XCremation 3 Re 4 Donation 5 Other (Specify)		A11 Count	matory or other cy Crema	place) ation 6-9-	-06 S	ykesvil	le, Md
<u>8</u>	Depermition of the control of the co		21. Signature of Funeral Service License Page Hought 2 23a. Part1. Enter the disease, or complice	ferbent	P.	0. Box	195 Sykes	ville, Md	21784	e & Chapel
	Physician /Medical		shock, or heeft failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	consequence of):	or the mode of	dying, such as cardia	o or respiratory arre	31,	Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
,0070	cate be executed physicien and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
O. BOX 0	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetel death 3	Ectopic pregna Other (specify			23d. Date of Month	
ב יה בי	w requires that been signed b should be deta	ρ	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderlying cause	given in Part I.	23e. Did tob		ute to the cause of death?
2 2 2 2 3 3 4 4 4 7	: The law receive hes be	Completed						24a. Was an autopsy perform 1 Yes 2	prio pd? dea	re autopsy findings available or to completion of cause of th? Yes 2 □ No
2	s certifi irector	o Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatien	* 3□ DOA		ath <i>(Check only on</i> e Home 5 ☐ Resider		(Case to
5	nding Phy ath. r: After thii e funeral c	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)		28c. l	njury at Work? 1 Yes 2 No	28d. Describe ho		(Specify)
22	To the Hospital or Attending Physician: The law within 24 bours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.				City or Town,	, State)	or Rural Route Number,
	the Hoep in 24 hou the Fune ipletely fil	edical	29a. Certifier Cartifying Phys (Check only 2 Madical Examinone)	ician: To the best of ar: On the basis of e and manner state	xamination and/or inv	vestigation, in n	ny opinion, death occ	urred at the time, da	te and place, and	I due to the cause(s)
	125	2	29b. Signature and title of certifier	'a mo)	29c. Lic	ense number 2058 (3)	29	d. Date signed (Month, Dey, Year)
	ر ۾ •		30. Name and address of person who both WM bur Kun 29	5 Stone	- Atre St	Print) - 307	Westmir	ster Mi	0 2115	7
	Sta Registr		31. Date filed (Month, Day, Year)	32. Receitrar	s Signature	1				

Amended Items 25 & 26 per Physician 06/06/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 29^{Day} Month **Physician** May 2006 9:30 A.M Emory Warfield Burdette, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Paradise Assisted Living Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 19 6. Sex 1**X**TXM 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Davs Hours 86 Yrs. Maryland 705-12-5797 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County r than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ₩ No Completed by Funeral Director Carroll Mt. Airv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 United States 6839 Runkles Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XCM o If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or iten any injury or other freumatic event, the Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2€XNo Specify: 3 ☐ Widowed 4 Divorced White 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Coltege (1-4or 5+) LPN Springfield State Hosp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emory W. Burdette, Sr. Susie Layton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 5924 Robindale Road Catonsville, MD Florence P. Kerrigan 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Lake View Mem. Park June 2, 2006 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory,
1212 W. Old Liberty Road Sykesville, M 21. Sign yure of Funeral Service Licensee MD 21784 a. P.xt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Death Immediate Cause (Final disease or condition resulting in death) mphy sem Pnysician Years /Medical Due to (or as con equence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 5 autopsy performcertificete 1 ☐ Yes 2 No Assisted Living 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 1 ☐ Yes 2 🗶 No Other: 4 Nursing Home 5 Tesidence 6 NOther (Specify) Facility 3 DOA 2 ER/Outpatient Certification: To this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature 11 completed cause of death (Item 23a) (Type, Print) -202

DHMH 17 Rev 1/2001

State Registrar

death \

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending

within 24 hours after To the Funeral Dire

State Registrar 29b. Signature and title of certifier

30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print) 110 Hospital Road, Guyneth A Blattau, 1903

and manner stated.

32. Registra Signature

158572 June 6, 2006 Suite 310 Prince Frederick MD 20678

		ı	1 - For State Registrar	State of	Maryland	•	artmen rtificate			and M	ental Hy	giene Reg. No.			9530
	Dhysisi	an.	1. Decedent's Name (First, Midd	lle, Last)							2. Date of Dea Month	Day	Yeer		. Time of Death
	Physici /Medio		Hazel	Faye	Brun	nbley					June 1	-			3:14
	Examin		4a. Facility Name (If not institution	on, give street and numb	er)		4b. City,	Town, or	Location o	f Death		4c.	County of De		
			9150 Bi-State		// /	to a filability of	De.	lmar	If Under:	24 Hre	0.0		Wicon		(Ott.)
	Funeral		5. Social Security Number 328–36–9278	6. Sex 7. 1 ☐ M 2 🖺 F	Age (In yrs. I.	ast birtnday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 3/11/1	y, Year)	9. 8	ountry)	(State or Foreign
	Director		Usuel Residence of Decedent								3/11/1	.942			11012
	/lend		10a. State 10b. Count	У	10c. City	, Town or Lo	ocation							10d.	Inside City Limits
	Man,	tor	Maryland Wice	omico	De	elmar									1 ☐ Yes 2X No
	within 72 hours after death with the Maryland ene than "natural", or liems 23a or 28a-1 ahow than "mayleal Exaltanar mant be coliffed at	Funeral Director	10e. Street and Number				10f. Zip					10g. Citi	zen of What C	Country?	
	15 wit	aiD	9150 Bi-State	e Blvd.				218	75				USA		
	eens eens	ner	11. Marital Status	12. Was Decede Armed Force		S. 13.	Was Deced	lent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)		14. Race - Art Black, Wh		ndian,
36	or it	by Fu	t Never Married 2 Ma	If Yes, Give			1 ☐ Yes		Specify:				Specify:		
21215-0036	ural LE	d b	3. Widowed 4 Divorce		95:	16a Daga	dent's Usua	I Ossupa	tion			16h Ki	WI nd of Busines	nite	
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12	withi ene than	шо	Elementary/Secondary (0-12)	College (1-4	or 5+)		gemen					Pro	perty		
	Hyg other	BeC	17. Father's Name (First, Middle	, Last)	!				18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
lan	Ald be Alenta rked tic av	To B	Charlie Edwar	cd Baldwin					Vir	gie	Victori	a Sy	yers		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylen if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic avent, its Medical Examination invalue collilled at		19a. Informant's Name/Relation								I Route Numbe			Zip Coo	de)
2	1 and 2 Health em 27 I		Ralph E. Brumb	ley/husband					e BTA		Delmar,				
Baltimore,	permit. Peges 1 ar Department of Hea Important: if Item any injury or othe ongle.		20a. Method of Disposition 1	3 ☐ Bernoval from Str	CE CE	lace of Dispo emetery, crea	matory or o	ther place			ate		cation - City o		
Ē	Peges ment of I		`4 □Donation 5 □ Other (MAT	comico				6/6/0			lisbur		
Salt	permit. Pe Departmen Important: any injury once:		21. Signature of Funeral Service	- Licensee		22	HOT10	d Addres. Way .	s of Facilit Funer	al H	lome Pro	fess	sional	Ass	ociation
	40 E = 0		23a. Part1. Enter the disease, of		CFSP						Salisb		MD 21		proximate
	Physician /Medical Examiner	niner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	as a consequence as a consequence		3res	st_	Ca	nc	er			On	set and Death
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rds, P	w requires that the de been signed by the a should be detached t	by	Part II. Other significant condit	ions contributing to deal	th but not resu	ulting in the u	inderlying c	ause give	n in Part I.		23e. Did to		9	to the ca robably	ause of death?
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Vital	icien: Th certificate rector, pag	BeC	25. Was case referred to medic	al					26. Place	of Death	(Check only of	7	1		
Ť V	× 5	ToE	examiner? t - Yes 2 No	Hospital: 1 ☐ înp		ER/Outpatier	nt 3 DO	Othe	^{IC} 4 □ Nu	rsing Hor	ne 5 Resid	ence 6	Other (Sp	ecify)	
n of	ding Ph h. After th funeral		27. Manner of Death Natural 5 ☐ Pend	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	f 2	8c. Injury Work	at ?		28d. Describe h	iow injury	occurred .		
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Ξ̈́	or Att	rtific		mined 286. Place of	f Injury - At ho I, etc. <i>(Specif</i> y	ome, farm, str /)	reet, factory	, office		1	28f. Location (S City or Tow		d Number or F	Rural Ro	ute Number,
			20 0-17 5-7-	District Test									 		
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certific	and manne	Stated.		290	License	number			29d. Date	e signed (Mor	nth, Day	, Year)
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23a. Part. Enter the disease or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Cause (Final Part 10 days) on constitution and Death 10 days 10 d	2	partm porte y Inju	Ì	21. Signature of Funeral Service Coer	nsee									ssociation
State St	۵	89 2 8 8		Kutt R Xh	enry CEST	2		501 Snow	Hill	Rd.,	Salisb	ury, ME	2180	04
Physician Modical Examiner Page Physician Physi				shock, or heart failure. List only	plications that caused one cause on each lin	the death. D	o not ent	er the mode of dyir	ng, such as	s cardiac or	respiratory arr	est,		Interval Between
Sequentially list conditions. Sequentially list conditions }			disease or condition	a. Extrem	3 PR	EMA	aturity					-	23 days	
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FEMALE 23b. Was decedent pregnant 1 23c. If yes outcome of pregnancy 23d. Date of delivery Month Day Year 1 Yes 2 No.		outed ansit	min	cause. Enter Underlying Cause (Disease or injury that initiated events	RESPIRE	story.	/)	SFRECS	Sy	ndno	omi=			13 days
FEMALE: 23d. Date of delivery Month Day Year	5	e exe		resulting in death) Last	Due to (or as	a consequed	e of):			- 10 H				7
25. Was case referred to medical examiner? 1 Yes 2 No No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 5 Pending Investigation 28e. Place of Injury 28b. Time of Injury M 1 Yes 2 No 28b. Describe how injury occurred 1 Secrity 1 Yes 2 No 28b. Describe how injury occurred 1 Yes 1 Ye		cate by			d			-						
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State of Maryland / Department of Health and Mental Hygiene [1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 4:27 1. Decedent's Name (First, Middle, Last) June 15, Day Year Physician 2006 Рм Helen Bernadette Campbell Landes /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Ridge 16405 Fishermen Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** Months 1 □ M 2 □XF 76 579-36-1304 1930 Director May 14, Pennsylvania Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r than "neturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Tyes 2 No St. Mary's Ridge Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 16405 Fishermen Way 20680 within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: à 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Нудівлв. Greeting Card Distrib Owner 12 filed 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth eny jury or other traumatic event sons. 17. Father's Name (First, Middle, Last) Be Mary Agnes Dever Charles J. Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16405 Fishermen Way, Ridge, MD 20680 Sharon Drury/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 19, 2006 Fredericksburg, VA 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Gardens 21. Signature of Furieral Service tiven a Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ano /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and s the burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: nse. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the Ö detached 9 Unknown 9 Unknown signed by t ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ The law requires 1 12 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Alter this certificate has autonsy performed? 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner's Hospital: 1 Inpatient Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Yes 2 THO 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how intury occurred Certification: the Hospitel or Attending Injury 1 Natural 5 Pending 1 ☐Yes 2 ☐ No death investigation 2 Accident within 24 hours after death To the Funerel Director. the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Destifying Physician: To the best of my knowledge, doubt becamed at the time, date and place, and due to the passe(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Db D56261 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Archana Gupta, MD Hollywood, MD 24035 egistrar's Signature 31. Date filed (Month State Registrar

Me

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	0.	uto 01 11	, ,		tificate c	of Deat	h			R	eg. No.	20	06		953
Physicia	ın/	Decedent's Nam	ne (First, Midd					-		-		Date of Dea Month	Day	Year		Time of De 0501 hr	
dical Examir	ner	Jos 4a. Facility Name (seph	Cas	SSIZZI	er)		4b. City. T	Town, or L	ocation of		June 7, 20		County of De		0301111	<u> </u>
3		4029 Fragil	,		st ario riombo	. ,		Ellico						ward			
Funeral		5. Social Security I	Number	6. Sex	7. A	ige (in yrs. la	st birthday)		er 1 Year	If Under		8. Date of Bir	th (MM/DI		Birthpla	ace (State	or
Director		212 50 0	492	1 X M	2_F .	59	Y	rs. Month	s Days	Hours	Min.	12/27	/1946	5	Countr	y) M)
any	I	Usual Residence of	of Decedent 10b. County	.= .		10c. City,	Town or Loc	ation							10	d. Inside (City Limits
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Maryland 28a-f show 1 at once.	Director	10e. Street and Nu		-				10f. Zip				1	0g. Citize	en of What C	ountry	?	
ith the Maryland 23a or 28a-f she notifi d at once		4029 Fr	agile						210					USA			
ath with the items 23a ist be noti	Funeral	11. Marital Status1 Never Marri	ried 2 🔀 M		Was Decede Armed Force	s?	S. 13. W	Vas Decede Yes, specif	ent of Hisp fy Cuban,	panic Origir Mexican, F	n? (Spec Puerto Ric	ify Yes or No can, etc.))- 14	4. Race - An White, etc		Indian, Bl	ack,
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5-0036 led within 7 Hygiene. other than	Som	17. Father's Name										irst, Middle,	Maiden S	urname)			
1214 d be fill lental F arked	Be	Jerome C					1405 14-11			There						- 0- 1-)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	٩	19a. Informant's N Marilyn										ral Route Nur Ellic)42
ore, les land of Heal		20a. Method of Dis	sposition X Crematio	n 3 R	emoval from	State	Place of Disp crematory or	other place)			Date		ocation - City			
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cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and the should be detached for use as the burial - transit	edical	UNPENDE	D		ENDED												
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Sox 687 death certific e attending for use as t	sician	past 12 month		4		at time of de	-44-	Other (Spe		Lotopio	programo	·,	1 "	Nonci	zuj		100
Box the death c y the atten hed for us	Phys	1 Yes 2 Part II. Other sign		itions cont	Unknown		esulting in the	e underlying	n cause di	iven in Par	+ 1	23e. Did t	obacco us	se contribute	to the	cause of	death?
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902		30. Name and add Carol Allar	·		leted cause of ledical Ex		111 Penr	n Street,	Baltimo	ore, MD	21201						
S Regis		31. Date filed (Mo.	JUN 0	9 200		trar's Signati	ure /	book									

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

			For State Registrar	State of Maryland		artment of I		nd Mental Hy	giene Reg. No.	2006	19534
	Physici		1. Decedent's Name (First, Middle, Last, Cecile Berman	Cooper				2. Date of De Month May 2			3. Time of Death 8:00P M
at all	/Medic Examir		4a. Facility Name (If not institution, give 15107 Interlachen	street and number)	7	4b. City, Town, Silve	r Spri	ng		ounty of Death	ry
	Funeral Director		5. Social Security Number 6. Sec. 257–84–7737	7. Age (In yrs. la 100	ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi Min. 7-26-1	705°	9. Birthp Cour Geors	place (State or Foreign http) gia
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment if Item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other traumatic event, the Modical Extrainment in notified at once.	by Funeral Director	10a. State 10b. County MD Montgom 10e. Street and Number 15107 Interlachen 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	ery Sil	3. 13. V	oring 10f. Zip Code 2090	lispanic Origin an, Mexican, F	i? (Specify Yes or No Puerto Rican, etc.)	U.S.A	en of What Cour	can Indian, etc.
Baltimore, Maryland 21215-0036	e filed within 72 ho Il Hygiene. other then "natur vent, the Modest	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)		(Give life. L	lent's Usual Occu kind of work done OO NOT use retire emaker	during most of d) 18. Mother's	Name (First, Middle		of Business/Ind Home umame)	dustry
, Marylar	and 2 should be saith and Menta 127 is marked or traumatic even	ToB	Louis Berman 19a. Informant's Name/Relationship (Ty Louis Cooper—son	рө, Print)	19b. Mailin 80 Ce	g Address <i>(Street</i> ntral Pa	and Number o	da Zucker or Rural Route Numb : New York	er, City or T	Town, State, Zip	Code)
timore	t. Pages 1 artment of He rtant: If Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ A 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 5 First Sovice License	emoval from State Bet Sho1	om Cer		5-	Date 31-06	Madi		ghts, VA
Ba	Depermine Deperm		23a. Part1. Enter the disease, or complishock, or heart failure. List only or		11	70 Rockv	ille Pi	Goldberg M ke Rockvi	11e,		
8760,	Physician /Medical Examiner burial-transit sthe burial-transit	dicai Examiner	snock, or near failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to himsolist cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	Adeno Ca	rcinoma	1			Interval Between
P.O. Box 6	law requires that the death certific. as been signed by the ettending pl 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ② No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3□	Ectopic pregnanc Other (specify)	1		230	d. Date of delive Month	ny Day Year
ords, P	w requires that been signed to should be deta	Ď	Part II. Dther significant conditions con	tributing to death but not resul	ting in the un	derlying cause giv	en in Part I.				e cause of death? ably 4 Unknown
tal Rec	The ate h page	e Completed	25. Was case referred to medical					1 ☐ Yes	osy ormed? 2⊠ No	prior to con death?	osy findings available inpletion of cause of
Division of Vital Records,	ding Phys h. After this funeral dir	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year)	R/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 ☐ Nursir	Death Check only of the property of the proper	dence 6)
DIVIS	교육등	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Tox	vn, State)	Vumber or Rural	
	To the Hospital Within 24 hours of To the Funeral completely filled	Medical	29b. Signature and title of certifier Authorities	icien: To the best of my know. Ier: On the basis of examination and manner stated. L. H. Churcher	and/or inv	29c. Licens	pinion, death c	occurred at the time,	date and pl	ad manner as stated ace, and due to signed (Month, E	the cause(s)
	Sta Registr		30. Name and address of person who co Catherine M. Chura 31. Date filed (Month, Day, Year)	MD 3305 North	leis	ure Worl	d Blvd	Silver Sp	ring	MD 2090	6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 6:18 P. M 26 2006 Helen Louise Chappell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Washington Hagerstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🖫 F 59 Yrs Director Virginia 13. 1946 228-64-9837 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f ehow other treumatic event, the Madical Examiner must be notified at 1X Yes 2 □ No Maryland Washington Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 Pennsylvania Avenue 21742 USA "natural", or Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be for and Mental H os 1 and 2 should be of Health and Menta Item 27 is marked Virginia Ruth Mason Joseph Edward Carrico, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9963 Stone Vale Dr., Jeanette M. Issa/Sister Vienna, Va. 22181 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I permit. Pages
Department of I
Important: If Its
eny injury o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State June 1. Oakton, Virginia Flint Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur • ur = uneraf Service Licensee 22. Name and Address of Facility 171 W. Maple Ave. Money & King Funeral Home, Inc. Vienna, Va. 22180 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 PNo 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death by not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 a. Was an autonsy certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Huspital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1/0 10 1 Inpatient 2 ER/Outpatient 3 DOA : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation nerel Director: A filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hoepitel or At within 24 hours after of To the Funerel Direct 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical ZL Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10045031

State Registrar

DHMH 17 Rev 1/2001

SHAHAB 2 SIDDIQUI

31. Date filed (Month, Day, Year)

Hagerstown, MD 21742

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue

gistrar's Signature

		1	State of Maryland / Department of Health and M 1 per Dr., G856, 06, 21, 106 dhb for Death	lental Hygier Reg.	ne 006	19536	
	Physicia	_	Decedent's Name (First, Middle, Last) Bonnie Callaway	2. Date of Death Month	Day Year	3. Time of Death 4. /3 PM	
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Luture Care Lockern Baltimore 4c. County of Death				
Ē	Funeral Director		6. Sex 1 Months Days Hours Min.	8. Date of Birth (Month, Dey, Ye July 13, 19	9. Bird 923 V	hplace (Stete or Foreign untry) irginia	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Hoportent: If term 21 is marked other then "naturel", or items 23a or 28e-1 show any injury or other treumetic event, the Neulcal Eventries must be notified at any injury or other treumetic event, the Neulcal Eventries must be notified at any.		Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
		. O L	Maryland Cecil Elkton 106. Street and Number 107. Zip Code		Citizen of What Co		
98		Funerai	886 East Old Philadelphia Road 1. Marital Status 1 □ Never Married 2 □ Married 1. □ Never Married 2 □ Married 1. □ Yes 2 ☒ No 1. □ Yes 2 ☒ No 1. □ Yes 2 ☒ No Specify:	ecify Yes or No-	United St 14. Race - Ame Black, Whit	nican Indian,	
215-003		Completed by	3 ☒ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ing 16b	. Kind of Business	Industry	
ıryland 2		Be Con	Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Page 19. Device Power of the Company of th				
		ဥ	William Rector Dossie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COORDAN WILLIAM Production of Code (No. 1)				
			Betty Anne Powers/Daughter 640 Red Hill Road, Elkton, Maryland 21921 20a. Method of Disposition 1 Burial 2 Micromation 3 Removal from State 1 Donation 5 Other (Specify) R. A. Ferris & Co. Inc. 1 Date Vest Chester, Pennsylvania				
Baltir			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921				
7	Hospitel or Attending Physician: The law requires that the death certificate be executed by A hours after death. Funerel Director: After this certificate has been signed by the attending physician and by D D D D D D D D D D D D D D D D D D		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition) Atheres I brotic Cardina Sullar Duse.				
			resulting in death) Due to (or as a consequence of): HYNOCHYNOIDISM				
		Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	<u>t.</u>			
09289			d.				
Division of Vital Records, P.O. Box			FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d.				
						o the cause of death?	
				24a. Was an autopsy performed	d? prior to death?	utopsy findings available completion of cause of	
		8	25. Was case referred to medical examiner? Hospital: Operation of SER/Outseties and DOA Other. A Physical Home of Desidence of Other (Specify)				
		on: To	1 Yes 2 No Parising Ho 27. Manner of Death (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work?	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
		Medical Certification;	2 Accident 3 Suicide 4 Homicide M 1 Yes 2 No	28f. Location (Stree City or Town, S		ural Route Number,	
			29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number D + 7 40 5	29d	Date signed (Mon	th, Day, Year)	
2	A		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIARAT ALI 821 N EUGW ST. Beltimme MD 2/20/				
Ì	St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2 1 2005				

			For State Registrar	State of Maryland		rtment of H			giene? () () ()	19537
			Decedent's Name (First, Middle, Last)		,		4	2. Date of Deat	th	3. Time of Death
	Physici /Medic		THO	OMAS	COL	BUR	N	J UV	02 2000	5 7:04P.M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			HOWARD COL	INTY GENERA	12 HOSP.	If Under 1 Year	UMB If Under 24 Hrs.	TH Boss of Birth	HOWF	Poles (State or Familia
	Funeral Director		5. Social Security Number 6. Sec. 1 \(\overline{\text{5.5}} \)	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry) ICT_OF_COLUMBIA
		ŀ	Usual Residence of Decedent					OCTOBER 2	22, 1929 DISIN	
	rylan show		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	Director	MARYLAND PRINCE GEO	RGES	CC	LLEGE PARK				1 ☐ Yes 2 ☑ No
	with the		10e. Street and Number			10f. Zip Code	740	1	10g. Citizen of What Cou USA	intry?
	eath	Funeral	4719 NANTUCKET ROAD	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Amer	ican Indian,
21215-0036	d within 72 hours after death with the Maryland jiene. I then "natural", or Items 23a or 28a-f show The Medical Examiliar must be molfilled at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1951-	1	Yes, specify Cuba ☐ Yes 2X No	sn', Mexican', Puèrto Specify:	Rican, etc.)	Black, White Specify: WHI	
9	72 ho natur	ted	15. Decedent's Edu (Specify only highest grade			ent's Usual Occup	ation during most of work	kina	16b. Kind of Business/l	ndustry
2	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	1)		TOWN ATTEN 6	10000
	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)			SURVEYO		ne (First Middle I	JOHN ALLEN & Maiden Sumame)	ASSOC
and	g d a g	o Be	THOMAS BRADLEY	7				VAN HORN		
Maryland	s 1 and 2 should be I Health and Mental Item 27 Is marked o other traumatic eve	ဂ္	19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street	and Number or Rui	ral Route Number	r, City or Town, State, Z	ip Code)
	aith a 27 ls r tra		RICHARD MOZINGO - SC	ON	8820 K	ING GEORGE	COURT, POM	FRET, MARY	YLAND 20675	
Baltimore,	of Hear	i	20a. Method of Disposition		lace of Disposemetery, cren	sition (Name of natory or other place		Date	20c. Location - City or 1	own, State
Ē	Pages ment of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	GEO			ETERY JUNE		ADELPHI, MA	
Salt	permit. Pag Department Important: I any injuty o		21. Signature of Funeral Service Licens	90 0	22	. Name and Addres	ss of Facility HIN	ES RINALD	I FUNERAL HOME	
	♦□ = ≈ 0		23a. Part1. Enter the disease, or compl	loven					ER SPRING, MAR	YLAND 20904 Approximate
	Pnysician /Medical Examiner	ier	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to or as a consequence.	u+e uence of):	My		1. 1	Infarchon	Interval Between Onset and Death 30 MINUTES
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
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8760,	cate be execute physician and the burial-trans	dlcal		. <u> </u>						
O. Box 6	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do	Ideath 3	Ectopic pregnancy	1		23d. Date of delin Month	very Day Year
Records, P.	uires that signed b ld be deta	by	Part II. Other significant conditions con	ntributing to death but not rest	ulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	
S	s been s should	Completed		9				24a. Was a	an 24b. Were aut	opsy findings available
Re	The la	оше						autops perform	sy prior to c med? death? 2⊠No 1 □ Yes	ompletion of cause of
Vital		Bec	25. Was case referred to medical				26. Place of Dea	th (Check only on		
of V	S S	ToE	examiner? 1 Yes 2 No	fospital: 1 Inpatient 2	ER/Outpatien		4 Nursing H	ome 5 Reside	ence 6 Other (Spec	ify)
0 0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury Wor	k?	28d. Describe ho	ow injury occurred	
Sio	death ctor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ama farm atr		Yes 2 □No	28f Location /Si	treet and Number or Rui	ral Poute Number
Division	or Attendated after death	Certification;	4 Homicide determined	building, etc. (Specify	y)	set, lactory, office		City or Town	n, State)	ar riodio i varioci,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After the Funeral Director or Attendentelly filled in by the fune			sician: To the best of my kno						
	he Ho in 24 I he Fu pletely	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my o	pinion, death occui	rred at the time, d	late and place, and due	to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	11- 1041	1 . 1 . 1 . 1	29c. Licens	e number	2	29d. Date signed (Month	, Day, Year)
1	MS		MISCUM	MUL KHA	IN IN	カー シー	+552	5	JUN C)5,2000
	0)0		30. Name and address of person who or	ckory R	idge	Print) ABO	SDA C	ALT K	Bia M	D 21044
	Sta Regist		JUN 6 2	32. Jegistrar's Signa	G A	all		·		

			State of Maryla	and / Depa				nd Mer	ntal Hyg	jiene	006	19538
			Stata Registrar	Ce	rtificate	of D	eath		R	leg. No.	000	10000
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2.	Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic Examin	al	Donald Robert Clark 4a. Facility Name (If not institution, give street and number)		4b. City, To	wn, or l	Location of		une 4,	2006 4c. Co	unty of Death	3:15 P ^M
	-Admini	,	101 Franklin Avenue		Si1v	er_	Sprir If Under 2	ıg		Mor	ntgomer	'y
	Funeral Director			vrs. last birthday) Yrs.		ays	Hours	Min.	Date of Birth (Month, Day ine 21	, Year)		place (State or Foreign ntry) fornia
			Usual Residence of Decedent	City, Town or Lo	nostion.							0d. Inside City Limits
death with the Maryland	show	ō										1 ☐ Yes 2 ☑ No
the M	28a-f	Director	Maryland Montgomery 10e. Street and Number	Silver S	10f. Zip Co	ode		-		10g. Citizer	n of What Cou	ntry?
with	3a or		101 Franklin Avenue			209	01			USA	A	
deat	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Deceden	t of His Cuban	panic Orig	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	14.	Race - Americ Black, White,	
0036 hours after	"natural", or items 23a or 28a-f show edicul Examinational benedified at	by Fu	1 ☑ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Year or Dates: 1.		1 ☐ Yes 212		Specify:				ecity:	
Maryland 21215-0036 d 2 should be filed within 72 hours af	stural cul Es		15. Decedent's Education	W II 16a. Dece	dent's Usual [occupat	tion			16b. Kind	Wh: of Business/In	
d 21215 filed within 72	ital Hygiene. id other than "natur event, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work of DO NOT use	done du retired)	unng most	of working	Ī	Montgo	omery C	County
2 W pg	Hygien	Con	2	Liquo	or Reta				First, Middle,		Governm	ient
and Be fi	Mental H arked ott atic even	Be	17. Father's Name (First, Middle, Last)				_			ferty	manie)	
aryla should	and Mental is marked aumatic ev	To	Donald Emanuel Clark 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (S	Street ar		race or or Rural R			own, State, Zip	Code)
	Heaith ar tem 27 is other trau		Christopher D. Clark Nephew		Willow		en Co	ourt	Manass	sas,V:	irginia	20110
altimore,	of He fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ob. Place of Dispo cemetery, cre Gate of	osition (Name	of er place)	Date	9	20c. Locat	tion - City or To	own, State
timor Pages	tment tant: jury o		* 4 □ Donation 5 □ Other (Specify)		Ceme	tery	yJ		2006 S	Silver	Sprin	g.Maryland
	Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Sign are o Funeral Service Licensee	Fı	2. Name and a	J.	Colli	ins Fu	neral	Home	, Inc.	MD 20001
	-		23a. Part1. Enter the disease, or complications that caused the o	death. Do not en	JO Univ	ers of dying	, such as	cardiac or re	espiratory an	rest,	Spring	MD 20901 Approximate Interval Between
Pł	າງວ່າວ່າລຸກ		Immediate Cause (Final									Onset and Death years
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petr	nsit	Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events c	,								
760, te be executed	physician and s the burial-transit		resulting in death) Last Due to (or as a con	sequence of):								
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X 68	iding p	/Med	IF FEMALE: 23c. If yes, outcome of pre					-		230	I. Date of deliv	ery
P.O. Box	ed by the attending phi detached for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ In the past 12 months? 4 ☐ Pregnant at time		□Ectopic preg □ Other <i>(spec</i>						Month	Day Year
О	l by th	hys	9 Unknown			-	The state of the s		220 Did to		contribute to t	he cause of death?
	been signed t	þ	Part II. Other significant conditions contributing to death but not Type 2 Diabetes	resulting in the t	underlying cau	se give	mmranti.					bably 4 Unknown
COL	been	Completed	Valvular Heart Disease						24a. Was		24b. Were auto	opsy findings available
Vital Records,	ate has page 2	omp	valvdiai neart bisease						autop perfor	rmed?	death?	ompletion of cause of 2□ No
		BeC	25. Was case referred to medical examiner?						Check only o			
of Vita Physician:	this ce al dire	은	1 X Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatie					5 🙀 Resid		Other (Speci	fy)
	Afte	lon:	27. Manner of Death 1 ★Natural 5 Pending (Month, Day Year) 2 ★Accident investigation	28b. Time (ar) Injury	M 280	lnjury Work 1 □ Y	rat t? ∕es 2 🗀 l		u. Describe r	low injury o	ccured	
Division or Attending	after death Director: I in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (St		treet, factory,	office	-	281	f. Location (S City or Tox		lumber or Run	al Route Number,
	al Dir	Cert										
Di ths Hospital or	within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examinar: On the basis of examinar and manner stated.	/ knowledge, dea mination and/or i	ith occurred at nvestigation, in	the tim	e, date an pinion, dea	id place, and th occurred	d due to the a	cause(s) an date and pl	nd manner as s ace, and due t	stated. to the cause(s)
Toths	within 2 To the complet	Me	29b. Signature and title of certifier		29c.	License	number			29d. Date s	igned (Month,	Day, Year)
15	N .		Kirline Woll		MD I) 9	9577			June	5, 2006	5
1,			30. Name and address of person who completed cause of death	(Item 23a) (Type	e, Print)	. . ^		0 #604	. Var	cinct	on MT	20895
	St	ate	30. Name and address of person who completed cause of death Richard H. Pollen, M.D. 10 31. Date filed (Month, Day, Year) JUN 6 2006 32 Registrar's S	Signature	pectici	IL A	venu	<u>e_#0U(</u>	<u>ken</u>	PTIIR C	עווין פווט	20077
	Regist	rar	JUN 6 2006 Maries	~ 7								

			1 = For State Registrar	State of Marylan		artment of H			giene	006	19539			
7	E Tes	2	Decedent's Name (First, Middle, Las	1)				2. Date of De			3. Time of Death			
	Physici /Medi		Kimberly Stro	ng Caple				June	Day 2	2006	505 PM			
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deatl	1	4c. C	ounty of Death				
90		.s	Washington County			Hage		\		ash.in				
	Funeral Director		216-94-8386	7. Age (In yrs.	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da May 15	th ly, Year) 196	Coun				
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits			
	be filed within 72 hours after death with the Maryland tal hygiene. d other than "natural", or itsms 23e or 28e-1 show event, the Modical Examinar must be notified at	tor	Maryland Washing	ton Sm	nithsbu	ıra					1 ☐ Yes 2 🗷 No			
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Coun	try?			
	ath w		22913 Berry Circ			217			ŲS					
	itsms itsms	Funerai	11. Marital Status 1 ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	12. Was Decedent Ever in U. Armed Forces? 1 Yes No	.S. 13. \	Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14	. Race - America Black, White, e	an Indian, etc.			
980	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1☐ Yes 2☐XNo	Specify:		S	pecify: Wh	nite			
21215-0036	72 ho	Completed	15. Decedent's Edi			lent's Usual Occupa		kına	16b. Kind	of Business/Ind	lustry			
121	within ne.	mpi	Efementary/Secondary (0-12)	Coilege (1-4or 5+)	life. I	DO NOT use retired,)	9						
р Б	filled v Hygie Ither t		N/A 17. Father's Name (First, Middle, Last)	N/A		N/A	18. Mother's Nan	ne /First Middle	Maiden Si	N/A				
Maryland	m = 0 5	To Be	Arthur N. Caple,	.Tr.			Nita S		Madon O	217/2110)				
ary	shou and M mar umat	-	19a. Informant's Name/Relationship (T		19b. Mailin	ig Address (Street a			er, City or T	own, State, Zip	Code)			
Σ	and 2 saith a n 27 is		Shirley Wrightson	Aunt	530.1	Mt. Holly	Dr. We	stminsto	er. M	21157				
ore	of He if item or oth		20a. Method of Disposition 1 Strategy Burial 2 ☐ Cremation 3 ☐ I	20b. P. Removal from State	lace of Dispo semetery, cren	sition (Name of natory or other place	9)	Date		ition - City or Tov	wn, State			
Baltimore,	t. Pag rtment rtent:		4 Donation 5 Other (Specify,	Sand		nt Cemete:		/2006	Finks	sburg, M	aryland			
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury or other traumatic a <u>once</u> .		21. Signature of Funeral Service Licens	100	22	. Name and Addres	s of Facility Pri	tts Fune	eral E	Home & C	hapel, PA			
	*		23a. Pap. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between											
Physician		fmmediate Cause (Final disease or condition		Me T	nonia					Interval Between Onset and Death				
4	/Medical		resulting in death)	a. Due to (or as a consequ	uence of):		1	đ						
oli Gar	Examiner		Sequentially list conditions,	b		tinal	O'b st.	ruetio	n					
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):									
	al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):									
760,	ate be executed hysicien and the burial-transit	cal	l	d										
68	ntifical ng phy as th		ICCENALE.											
gox	leath certifica attending ph I for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Fetal		Ectopic pregnancy			230	d. Date of deliver	•			
.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)				Month [Day Year			
۳.	res that the de signed by the a be detached f	y Ph	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the un	iderlying cause give	n in Part I.	23e. Did to	bacco use	contribute to the	a cause of death?			
Records,	w requires been sign should be	ed by						1 🗆 Y	′es 2 🗆 I	No 3 ☐ Proba	ibly 4 Unknown			
ဝင္ပ	law re	Completed						24a. Was		24b. Were autop:	sy findings available			
Ĕ	hysician: The law nis certificate has t I director, page 2 s	Com							med? 2 ☐ Mo	prior to com death? 1 \(\text{Yes} \) 2	pletion of cause of			
/ita	cian: ertific ector,	Be (25. Was case referred to medical examiner?			7	26. Pface of Dea							
of o	Physi this o	2	To res 21 No		ER/Outpatient		4 🗆 Nulsing H	ome 5 Resid						
\subseteq	fte	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? ′es 2 ⊡No	28d. Describe h	ow injury o	ccurred				
Division of Vital	Attending or death. ector: After by the funer	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, stre		03 2	28f. Location (S	Street and N	lumber or Rural	Route Number.			
	s efte el Dire ed in t	Certification;	4 Homicide determined	building, etc. (Specify	1)			City or Tow	n, State)		,			
	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A or mpletely filled in by the fu	edical	Chock only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat	wledge, death	occurred at the time	e, date and place, inion, death occur	and due to the o	ause(s) an	d manner as stated	ted.			
	othe ithin 2 othe mplei	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License				igned (Month, D.				
)	FSFO			when			60396			05 10				
	MJ		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type F			1		/				
	4			- SHED	. , , , , , , , , , , , , , , , , , , ,		- 4	1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	יונ מיי	140			
	Sta	23	31. Date filed (Month, Day, Year)	32. Registrar's Signat		/	1100)	,		+			
J. P. P.	Registr	ar	JUN 0 7 21	006 Seem	D. A	redu								

		•	For State Registrar	State	of Marylar		artment <i>tificate</i>			d Menta	l Hygie Reg.	711	06	19	540
H	Physici	_	Decedent's Name (First, Middle BLANCHE PAYNE							Mo	e of Death nth /31/20	Day \	/ear	3. Time of 2330	Death
•	/Medio Examin		4a. Facility Name (If not institution SOUTHERN MARY	_			4b. City, To		ocation of D	eath		4c. County of		RGE'S	
	Funeral Director		5. Social Security Number 578-34-9149	6. Sex 1 ☐ M 2 🛱 F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1	Year I	1 Under 24 Hours		o of Birth oth, Day, Ye 3/24		Birthp	lace (State of	
	filed within 72 hours after death with the Maryland Hygiene. the them 'naturel', or items 23e or 28e-f show int, the Medical Examiner must be notified at	Director		GEORGE'S		ity, Town or Lo APLE HI	LLS							0d. Inside Cit	•
	death with the ms 23a or 2	Funeral Dir	2011 KEATING ST	12. Was Dec	cedent Ever in U	J.S. 13.)	10f. Zip C 2074 Vas Decede	8	anic Origin	? (Specify Ye	USA	14. Race	Americ	an Indian,	
9600	urei', or ite	þ	1 Never Married 2 Marr 3 Widowed 4 Divorced	If Yes, G Year or I	2∭X No ive		1⊡Yes 2∭X	Ū No .	Specify:	rueno Rican, e		Specify:V		E	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental trygiens is marked other then "naturel" or items 23a or 28a-f show is marked other then "naturel" or items 23a or 28a-f show aumatic event, it a Madical Examinar must be nutified at	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t grade completed) (1-4or 5+)	(Give	lent's Usual kind of work DO NOT use AKER	done dur	on ing most of	working		o. Kind of Busi WN HOM		lustry	
/Jand	m - 0 5	To Be C	17. Father's Name (First, Middle, WILLIAM NEWTO							Name (First, IE DARB		den Sumame)			
, Mar	and 2 sho ealth and I n 27 is mu		19a. Informant's Name/Relations ROBERT B. CODLI			2011	KEATIN	IG SI		r Rural Route IPLE HI	LLS, 1	1D 2074	18		
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Mental Important: If item 27 is marked any injury or other traumatic et one.		20a. Method of Disposition 1	oecify)	State	Place of Dispo cemetery, cren DAR HIL	natory or oth L CEME	er piace) ETERY		Date 0/03/20 DAKSHAL	06 S1	Location - C	, M	D	
Pa	Deper Impor		21. Signature of Funeral Service	D.M.	arsh	all 4	308 SI	JITLA	ND RD	. SUIT	LAND,				
,	Physician /Medical Examiner		shock, or hear failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	each line.	in pa	er in mode	or dying,	SUCIT AS CAT	diac or respin	atory arrest,		4	Approximate Interval Betwoonset and D	ween Death
8760,	icate be executed physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, backing to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	(or as a consec										
P.O. Box 68	ath certit attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live	utcome of pregn birth 2 Fets nant at time of a nown	aldeath 3 ☐	Ectopic preg Other (spec					23d. Date Month		,	- /ear
	requires that the de been signed by the should be detached	Ď	Part II. Other significant condition Draf Ca	ons contributing to	death but not re	sulting in the u	nderlying cau	ise given	in Part I.	236	e. Did tobaco	co use contrib	ute to th		eath? Inknown
Vital Records,	The law recete has being page 2 sho	Completed								-	a. Was an autopsy performed	? dea	ath?	psy findings a inpletion of ca 2 No	available ause of
f Vita	Physician: The la this certificete ha ral director, page 2	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 No	Honoitali	Inpatient 2] ER/Outpatien	t 3□ DOA	Other		Death (Checking Home 5		6 □Other	(Specify	<i>'</i>)	
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Certification;	27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could	gation	nth, Day Year)	28b. Time of Injury	М		s 2 🗆 No			njury occurred			
<u>></u>	pital or A ours after eral Direc		4 Homicide determ	g Physician: To th	e of Injury - At h	ify)			date and n	City	or Town, S				oer,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only 2 Medical one) 29b. Signature and title of certifie	Examiner: On the I	nasis of examin	ation and/or in	estigation in	nino vm c	ion death o	occurred at the	a time date	and place and	d due to	the cause(s)	
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	Sta Registi		JUN 0 6 2	006	negistrar's Sign	goo!	w								

	1	For State Registrar 1. Decedent's Name (First, Middle, I	State of M	iai yiai i				Death	and w	_	Reg. No.	U U b	3. Time of Death
Physicia /Medic Examin	an al	M. MARVIN DOL 4a. Facility Name (If not institution, g TALBOT HOSPICE	INSKY)	· · · · · · · · · · · · · · · · · · ·	4b. City,		Location o	of Death	Month JUNE	3 Day	2006 unty of Death	10:16AM
Funeral Director		5. Social Security Number 6 135-18-7082 Usual Residence of Decedent	. Sex 1▲ M 2□ F	ge (In yrs.	last birthday) Yrs.	If Unde Months	n 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da OCT 23	, Year) 1922	9. Birth:	place (State or Fore htry) JERSEY
Ba-f show	ector	10a. State 10b. County MD TAL	вот		y, Town or Lo								10d. Inside City Lim
h with tr	ai Dire	10e. Street and Number 610 DUTCHMANS L	ANE			10f. Ziş	Code 2	1601			10g. Citizer	of What Cou	
n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show calcal Ext. item must be notified at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces d 1 X Yes 2 ☐ If Yes, Give Year or Dates:	?	i	Was Dece f Yes, spe I 🗆 Yes		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, ecify: WH	etc.
iin 72 h	Completed by	15. Decedent's (Specify only highest (grade completed)	F.\\	16a. Deced (Give life.	lent's Usu kind of wo DO NOT u	al Occupa ork done d se retired,	ition <i>uring mos</i> i)	t of worki	ing	16b. Kind	of Business/In	dustry
filed within Hygiene.	Com	Elementary/Secondary (0-12)	College (1-4or	5+)	SA	LESM	an						CTURER
should be filed within nd Mental Hygiene. marked other than imatic evant. It a M	To Be	17. Father's Name (First, Middle, La BARNETT DOLINS	SKY					R	OSE 1	ROSENFE	LD		
nd 2 sho tith and 27 ia m r traum		19a. Informant's Name/Relationship BETTY JO PRICE/				•	•			al Route Numbe			•
of Hea of Hea If item or otha		20a. Method of Disposition **X** Burial 2 Cremation 3	☐Removal from State		Place of Dispo cemetery, crer	sition (Na.	me of other place	9)	[Date	20c. Locat	ion - City or To	own, State
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event. If a Medical once.		' 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lic	cify)		FORD C	. Name a	nd Addres	s of Facilit	V	/2006 N_&_NEW		RD, MAR INERAL	YLAND HOME PA
Physician /Medical kaminer /Asicien and e privial-transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	keto s	unce of: unce of: unce of): unce of):	leng	dis enor	eese eliza	L				neux y.cers
death certifica e attending phy d for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic p					23d	Date of delive	ery Day Year
uires that signed b id be deta	by	Part II. Other significant conditions	s contributing to death	but not res	ulting in the u	nderlying o	cause give	n in Part I.			bacco use		he cause of death
aician: The law requires that the certificate has been signed by the lirector, page 2 should be detache	Completed									24a. Was autop perfor			psy findings ava mpletion of caus 2 \(\square\) No
ding Phy n. After this funeral d	To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Natural 5 Pending investigat	28a. Date of Inj (Month, Da	ury	ER/Outpatier 28b. Time of Injury		28c. Injury Work	at 4 □ Nu	rsing Ho	n (Check only o	ence 6	Other (Specificurred	Hospie
	Certification;	3 Suicide 6 Could not determine	t be 28e. Place of Ir	njury - At he etc. (Specif	ome, farm, str (y)	eet, factor	y, office			28f. Location (S City or Tow	itreet and N n. State)	umber or Rura	ul Route Number,
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical (29a. Certifying (Check only one) Certifying 2 Medical Ex	Physicien: To the best eminer: On the basis and manner s	of examina	wiedge, death	occurred estigation	at the tim	e, date an inion, dea	d place, a	and due to the o	ause(s) and date and pla	d manner as s ce, and due to	tated. the cause(s)
To the within To the comp	M	29b. Signature and title of certifier	Make	297		29	c. License		93	-19		gned (Month. 6-5-0	
4.	-	30. Name and address of person wh	no completed cause of	death (Iten	n 23a) (Type.	Deint)							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month e WAR LIBRED 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUNRISE AT DE VERNA ARK Severna Park
If Under 1 Year | If Under 24 Hrs. Anne Arundel 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F Director 244-24-1474 1925 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Mcdical Examiner must be notified at Anne Arundel Severna Park Funeral Director 1 Yes 2 XNo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 43 McKinsey Road 21146 USA tiled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Professional Librarian Education permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: if tiem 27 is marked other say singry or other traumatic event ang. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Frank Eller Golda Velt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Dewar/Daughter 2909 Westfield Avenue Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 7 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Arbor Grove UMC Cem. Purlear, NC 2006 21. Signature of Europal Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD21146 La 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exects) Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conflibute to the cause of death? Division of Vital Records, Completed by Dementia 3 Probably 4 Unknown PARKINSONS DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy OSTEOPOPOSIS certificate 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier June 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

MICHAEL ANKIZOM 5505 HOPKINS BAYVIEW CIRCLE BAZTMORE MD 21224

State Registrar

			1 - For State Registrar	State of Maryla			te of D			Reg. N	600	6 19543
	Physicia /Medic		Decedent's Name (First, Middle, Last) Alice		avitian				2. Date of Month June		ay Yea	
	Examin		4a. Facility Name (If not institution, give Suburban Hospital			Bet	hesda			М	c. County of D lontgom	ery
	Funeral Director		5. Social Security Number 233-32-1090 Usual Residence of Decedent	7. Age (In yrs	i. last birthday) Yrs.		Days	If Under 24 Hrs Hours Min	8. Date of Month,	Birth Oay, Year 0 192		Birthplace (State or Foreign Country) Virginia
	permit. Pages 1 and 2 should be lied within 72 hours after death with the maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any Injury or gither traumatic event, the Madical Examiner must be notified at once.	Funeral Director	MD Montgome 10e. Street and Number 8900 Walden Road		ity, Town or Lo	5 pri 1	p Code				itizen of What	•
920	ours andr deam iral', or Itams 23 Examiner musi	þ	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces? 1 □ Yes ※XNo If Yes, Give Year or Dates:	-			panic Origin? (Mexican, Pue Specify:	Specify Yes or to Rican, etc.)		14. Race - A Black, W Specify: W	merican Indian, hite, etc.
S	filed within 72 in Hygiene. ther then "natu int, the Medical	e Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)		(Give	kind of w OO NOT	use retired)	ring most of wo Office:		US		ss/Industry ation Agency
Maryland	should be filed vind Mental Hygie marked other t	To Be	Karnig M. Davitia		19b. Mailir	ng Addres		Sruhee	Ayania	an		a, Zip Code)
	Fages 1 and 2 nent of Health a snt: If item 27 le rry or other trac		Salpee Sahagian / 20a. Method of Disposition 1 🌣 Burial 2 □ Cremation 3 □ F	20b.	Place of Dispo cemetery, crer	sition (Na	ame of other place)		kville,	20c. l	Location - City	or Town, State
	permit. Pag Department Important: I any Injury once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licens			. Name a	nd Address	of Facility Jo	9,2006 Seph Ga NW Wa	wler	's Sons	s Inc.
4	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Pneumonia Due to (or as a conse	ath. Do not ent	er the mo	de of dying,	such as cardia			•	Approximate Interval Between Onset and Death
68760,	ricate be executed physicien and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.								
Box 6	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	3c. If yes, outcome of preging the preging the last time of a Unit of the last time of time of the last time of time of time of time of time of time of time o	tal death 3 □	Ectopic Other (s	pregnancy specify)			-	23d. Date of o	delivery Day Year
Records, P	law requires thet the as been signed by th ? should be detache	ρ	Parkinsons Dise	-		, ,	•				use contribute	to the cause of death? Probably XXUnknown
α	Ihe ate h cage	Completed	Heart Failure							topsy rformed?	24b. Were prior 1 death	autopsy findings available to completion of cause of ? es 2 \leftig No
on of Vital	ding Physician: In n. After this certificate funeral director, pag	tion; To Be	27. Manner of Death 1 Anatural 5 Pending	1 Elnpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		OA Other 28c. Injury a Work?	4 ☐ Nursing	ath (Check on) Home 5 ☐ Re 28d. Describ	sidence		pecify)
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec					28f. Location City or 1	(Street a Fown, Stai	and Number or te)	Rural Route Number,
	ine Hospil in 24 hour he Funera pletely fille	Medical ((Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, death nation and/or in	vestigatio	n, in my opir	nion, death occ	e, and due to thurred at the time	e, date ar	nd place, and d	lue to the cause(s)
	10	Σ	29b. Signature and title of certifie		vilks_		D0063		-		ate signed (Mo e 2 200	onth. Day, Year) 16
	Sta	ate	30. Name and address of person who con Steve Wilks MD 86 31. Date filed (Month, Day, Year) JUN 6 20	00 01d Georg	etown R			la, MD	20814			

			1 - For State Registrar	State of Ma	a ryla nd / Dep <i>Ce</i>	artment of F		-	giene 200	6 19544
	Physic	ian	Decedent's Name (First, Middle, Last George A) Lbert	Dame			2. Date of De Month May	31, 2006	3. Time of Death
The most	/Medi Examir		4a. Facility Name (If not institution, give Eden Pine Assisted	street and number)		4b. City, Town, or Hagerst	Location of Death		4c. County of De Washing	eath
	Funeral Director		005 12 0401	x 7. Ag 7. M 2□F	80 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept.	19. B 19. S 19. S 19. S 19. B 19. B 19. B	irthplace (State or Foreign Country) W Hampshire
	e Marylend	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	Georges	10c. City, Town or L					10d. Inside City Limits 1 Yes 2 □ No
	23a or 2	Funeral Director	10e. Street and Number 9238 Limestone P.	lace		10f. Zip Code	20740	Ţ	10g. Citizen of What (Inited Stat	Country? es of America
980	d within 72 hours effer death with the Maryland Jene, r than "natural", or Itema 23a or 28a-1 ahow the Madical Examinar must be notified at	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	12. Was Decedent I Agned Forces? 1 Yes 2 N If Yes, Give Year or Dates:	1971 III A	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No		pecify Yes or No o Rican, etc.)		
Maryland 21215-0036		Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	(Give	dent's Usual Occupi kind of work done of DO NOT use retired tor of Aud	during most of wor)		Americal As	
/land	e file el Hyg I othe vant,	To Be C	17. Father's Name (First, Middle, Last) Chester Harold]	ame	,,,,		18. Mother's Nam Helen E		Maiden Sumame)	
	ea 1 end 2 should b of Heelth end Ment of Itam 27 ia marked r other traumatic a		19a Informant's Name/Relationship (7) Allison Ann Ryan	pe, Print) - Daughter	: 80 Y	ellow Popi	lar Lane	ral Route Number , Hedges	er, City or Town, State, SVI11e, WV	Zip Code) 25427
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Ft. Linco	osition (Name of matory or other place oln Cremat	tory 06/1			, Maryland
Balt	permit. Peg Depertment Important: any injury o	2	21. Signature of Funeral Service Licens			<u>11800 New</u>	_Hampshiı	ce Ave,	Silver Spr	Home, Inc.
8760,	deeth certificate be executed X Medical Be ettending physicien end d for use as the buriel-transit and for use as the buriel-transit The state of the stat	dical Examiner	23a. Party Enter the disease, or composed, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of): Awial a consequence of): Consequence of): Consequence of): Consequence of):	Heart Antany Fiblia	Failure diseas		(1931)	Approximate Interval Between Onset and Death
.O. Box 6	the transfer of the transfer o	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
<u>α</u>	The law requires that that the has been signed by sego 2 should be detected.	à	Part II. Other significant conditions co	ntributing to death bu	nt not resulting in the u	nderlying cause give	n in Part I.		obacco use contribute t	o the cause of death?
of Vital Records,		Completed		F				1□ Yes	sy prior to death?	utopsy findings available completion of cause of s 2 No
Division of Vit	inding Physath. ath. or: After this oe funerel di	Certification; To Be	25. Was case referred to medical examiner? 1	28a. Date of Injun (Month, Day	ry - At home, farm, str	28c. Injury Work M 1 \(\triangle Y	4 Daursing no	ome 5 Resid 28d. Describe h	ience 6 Other (Spe ow injury occurred	
	spite hours neral filler	edical Ce	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	cian. To the best of ter: On the basis of and manner stat	examination and/or inv	r secured at the tank restigation, in my op	e, date and place, inion, death occur	and due to the e red at the time, o	ause(s) and manner a date and place, and du	s stated. a to the cause(s)
)	To the Ho within 24 I To the Fu	Me	29b. Signature and title of centre		·	29c. License	number 6 UV3	2	29d. Date signed (Monitor) 6/1/0/2 8 WW, MD	th, Day, Year)
			30. Name and address of person who co	LUM, M	ath (Item 23a) (Type,	MILL STRE	FET, 4.	AGERST	OWN, MO	-21740
	Sta Registr		31. Date filed (Month, Day, Year) JUN 6 20	456	r's Signature	uli .				

			1 - For State Registrar	State of M	arylan				ealth a	and M	-	giene Reg. No.2	006	195	45
	Physici		Decedent's Name (First, Middle, Las DAVID L. DOWNING	t)							2. Date of De Month	ath Day	Year 2006	3. Time of D	
}	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		<u> </u>	4b. City,	Town, or	Location o	of Death	9		ounty of Death	l	
		ø	PENINSULA REGIONA					LISB r 1 Year	URY If Under	Od Hre			VI COMI CO		
	Funeral Director		5. Social Security Number 6. Security Number 216-44-8305	M 2 F	61	ast birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da 11-29-	y, _{Year)} 1944	MARY	lace (State or a try) LAND	Foreign
	yland how		10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City	
	ter death with the Marylan Iteme 23a or 28e-f ehow Inst.must be notified at	Director	MD WICOMI	CO	FRU	UITLAN								Y□Yes 2	2 No
	with the	Dir	10e. Street and Number 100 HAYWARD AVENU	TIE:			10f. Zij	Code	21826			10g. Citize	n of What Cour USA	try?	
	death me 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Dece				ecify Yes or No Rican, etc.)	- 14	Race - Americ		
980	8 9 E	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X☐ If Yes, Give Year or Dates:			r Yes, spe 1 ☐ Yes		Specify:	, Ривпо	Hican, etc.)		Black, White, pecify: WH	etc. LTE	
5-0	72 hours "natural", dicti Exe	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Dece (Give	kind of wo	ork done a	luring most	of work	ing	16b. Kind	of Business/Inc	dustry	-
121	d within gene. rr then "	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOTA RECTI		OFFI	CER		COI	RRECTIO	NS	
<u>م</u> 2	Hyg Th	BeC	17. Father's Name (First, Middle, Last)								First, Middle,				
ylaı		To E	ALTON HARRIS DOWN	NING					ANNA	BELI	LE DORM	AN			
Maryland 21215-0036	12 2 4 7 1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		19a. Informant's Name/Relationship (7 SHARON DOWNING -				-				al Route Numbe JITLAND				
Baltimore,	ta ita		20a. Method of Disposition 1 \(\times \text{Burial} \) 2 \(\text{Cremation} \) 3 \(\text{Disposition} \)	Domoval from State	20b. P	lace of Dispo emetery, crei	sition (Na	me of other place	e)		Date	20c. Loca	tion - City or To	wn, State	
Ë	Pages tment of tant: If it jury or o		4 □ Donation 5 □ Other (Specify)	ST	. PHIL						•	ICO, MA		
Bal	permit. Page Department of Important: If any injury or		21. Signature of Foneral Service Licens	uy Bli	ko.						JNDS FUI F,SALISI				ŀ
8760,	The law requires that the death certificate be executed to the attending physicien and to proper a sage 2 should be detached for use as the bursal-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sep Due to (or as Due to (or as Due to (or as Due to (or as	a consequ	uence of): ON 6 J uence of):	pn	evm	ml	a				Onset and De	ath
P.O. Box 6	at the death certific by the attending pitached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic p Other (sp		-			230	d. Date of delive Month	ry Day Ye	ar
	uires that signed t id be det	ል	Part II. Dther significant conditions co	1 1	out not resu	ılting in the u	nderlying (ause give	on in Part I.			obacco use (es 2 1 1	contribute to th	/	
Vital Records,	aw requir as been si 2 should	Completed	1								24a. Was		24b. Were autor	sy findings av	ailable
Ä		Com										rmed? 2 No	death?	npletion of cau 2□ No	se or
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only o				
ō		. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	iry	ER/Outpatier 28b. Time of		28c. Injury Work	4 🗀 190		me 5 Resid)	
ion	들근동호	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	М		? ∕es 2 🗆 l	No					
Division	i dita	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	ury - At ho c. (Specify	me, farm, str	eet, factor	y, office			28f. Location (S City or Tow		lumber or Rura	Route Numbe	3r,
	To the Hospital or Al within 24 hours after or To the Funerel Direct completely filled in by	edicai (29a. Certifier 1 ☑ Certifying Phyone) 2 ☐ Medical Exam	rsician: To the best iner: On the basis o and manner st	t examınat	wiedge, death ion and/or in	occurred vestigation	at the tim	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) an date and pla	d manner as stace, and due to	ated. the cause(s)	
	within To the	Š	29b. Signature and title of certifier	1/1				c. License	c a .			60	igned (Month, I	Day, Year)	
•	B		you del	Im	1at #:	00-1 T	Daile 13	MOG	593	568		<i>Q</i>	1210		-
_	10		30. Name address of person who o	100 E	eath (Item	Grrol	Sŧ.	Sa	lish	ry	MO	2180	04		
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 5 2	32. Registr	ar's Signat	ture	hards	,		J					

DHMH 17 Rev 1/2001

			1- For State of Maryland / De Registrar	partment of Health a ertificate of Death		ene2006 19546	5
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death	_
	Physici /Medic		Sue Maksim Eikamp		June	13 2006 11:30 a ^M	
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	Death	4c. County of Death	
			St. Mary's Hospital	Leonardtown		St. Mary's	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd:	Months Days Hours	4 Hrs. 8. Date of Birth (Month, Day,) 2-11-19	(ear) 9. Birthplace (State or Foreign Country))
	Director		065-09-2136 Sylval Residence of Decedent		2-11-19	17 New Jersey	_
	yland now		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits	Т
	Man a-1 eh	ţor	Maryland St. Mary's L	exington Park		1 ☐ Yes 2 No	
	or 28	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?	_
	ath with the Marylan 23a or 28a-1 show	ai	48566 Havirland Road	20653	U	nited States	
36	n 72 hours after death with the Maryland "naturel", or Iteme 23a or 28a-f ehow waltal Examinat must be nutified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ₺ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ₺ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican, Yes 2 No Specify: 	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
Ş	2 hou	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation	16	Sb. Kind of Business/Industry	_
215	_ = 20	Completed	(Specify only highest grade completed) (G	ve kind of work done during most (). DO NOT use retired)	of working	,	
21	TO 100 by 100	ωоς		omemaker		Own Home	
힏	be filed tal Hygid d other	Be (17. Father's Name (First, Middle, Last)		s Name (First, Middle, Ma	uiden Sumame)	
yla		2	George Maksim		y Mihalyo		
, Maryland 21215-0036	7 19		19a. Informant's Name/Relationship (Type, Print) Paul Eikamp/Son 310	oiling Address (Street and Number O S. Manchester	Street, #11.	City or Town, State, Zip Code) 22044 5, Falls Church, VA	
Baltimore,	- 도움들		1 Burial 2 □ Cremation 3 □ Removal from State	position (Name of rematory or other place) d Veterans	6-21-2006	oc. Location - City or Town, State Cheltenham, MD	
Balti	permit. Pages Department of I Importent: If It eny Injury or o		21. Signature of Funeyal Service License John Love M01422			Funeral Home, P.A.	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as ca	ardiac or respiratory arres	t, Approximate Interval Between	
	Physician /Medical Examiner			hock	7	Onset and Death	_
58760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of).	ensing			_
89	g phy as the		U				
P.O. Box	thet the death certific ed by the attending p deteched for use as	Physician/Me		B Ectopic pregnancy		23d. Date of delivery Month Day Year	
	iaw requires thet the as been signed by 2 should be detec	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
al Records,	The ate h	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	1 04	f Death Check only one		-
5	Phys this ral dii	٠ <u>۲</u>	1 ☐ Yes 2 ☑ No Prospitar: 1 Inpatient 2 ☐ ER/Outpat 27. Mann of Death 28a. Date of Injury 28b. Time		ing Home 5 Residence 28d. Describe how		1
5	ding h. After fune	tol	1 Natural 5 Pending (Month, Day Year) Injur			injury occurred	
Division	il or Attending affer death. Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)			et and Number or Rural Route Number, State)	i
_	Hospite 4 hours Funeral ely fillec	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de (2 Medical Exeminer: On the basis of examination and/or and roanger stated.	ath occurred at the time, date and investigation, in my opinion, death	place, and due to the caus occurred at the time, date	se(s) and manner as stated.	10
	To the within 2 To the complet	Med	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Menth, Day, Year)	_
	F>F0		· man	Dao 622	13 6	5 14 02	
			30. Name and address of person who completed cause of death (Item 23a) (Type Suresh Patel, 25500 Point Lookout		own, Marylan	d 20650	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	da:			

			1 - For State Registrar AMED#23a(a)+1	State of Maryla						ene 200	6 19547
	Physici /Medic		1. Decedent's Name (First, Middle, Las	uinton		Emery		2. 00	ate of Death lonth ne 5	, 2006	3. Time of Death 5:00A. M
}	Examin	er	4a. Facility Name (If not institution, give 4218 Ulster Road 5. Social Security Number 6. S	ex 7. Age (In yi	s. last birthday)	If Under 1 Year	ltsvi	.11e	ate of Birth	9. B	e George's
	Director		204-26-0136 1 Usual Residence of Decedent 10a. State 10b. County	X M 2□F	73 Yrs.	Months Days	Hours	Min. Ma	iy30,19	133 Pe	nnsylvania
	be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other then "netural", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Funeral Director	Maryland Prince G 10e. Street and Number 4218 Ulster Road 11. Marital Status	12 Was Decedent Ever in	Beltsvil	10f. Zip Code	0705	rigin? (Specify Y		United S	tates
-0036	thours after estures, or ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced		-1 955	1 ☐ Yes 2 No	Specify	r.		Specify:	White
9500-61212	iled within 72 Hygiene. ther then "not, ine Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last,	College (1-4or 5+)		kind of work done DO NOT use retire Driver		est of working			Foundation
Maryland	Mental Mental Irked c	To Be	Arthur C. Emery 19a. Informant's Name/Relationship (Type, Print)			Oliv	Te Emma	Gibs	SON City or Town, State,	
	ges 1 end 2 sho t of Heelth and I if item 27 is mu or other treums		Billie J. Emery - 20a. Method of Disposition 12 Buriai 2 Cremation 3	20b	. Place of Dispo cemetery, cre	osition (Name of matory or other pl	ace)	Date	20	aryland 2	or Town, State
Baltimore,	permit. Pages Depertment of I Importent: If its eny injury or o		4 Donation 5 Other (Specifical Signature of Funeral Service Licer	v) Ma	W 13	Name and Addr	ess of Facil	wardt Fu	uneral	Home, PA	ham,Maryland A aryland 20705
8/60,	The law requires that the death certificate be executed by WK and has been signed by the attending physicien and in pip compage 2 should be detached for use as the burial-transit and in the compage 2.	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Saus Ilay list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons d.	equence of):	ter the mode of dy	ing, such a	s cardiac or resp	piratory arrest	t,	Approximate Interval Between Onset and Death
P.O. Box 6	st the death certific by the attending p tached for use as i	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pred 1 □ Live birth 2 □ Fi 4 □ Pregnant at time o 9 □ Unknown	etal death 3[□Ectopic pregnand □ Other (specify)	су			23d. Date of d Month	elivery Day Year
	w requires thet been signed b should be deta	Completed by Pl	Part II. Other significant conditions of Diabetes Mellitus Hypertensive Caro	s Type II;		inderlying cause g	iven in Part			2 □ No 3 📉 I	to the cause of death? Probably 4 □Unknown autopsy findings available occupietion of cause of
/ital He		Be	Peripheral Vascu 25. Was case referred to medical examiner?	lar Disease				e of Death (Che		d? death? XNo 1 ☐ Ye	os 2□ No
Division of Vital Records,	tal or Attending Physician: s after death. el Director: After this certific ed in by the funerat director,	sation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation			of 28c. Inju		28d. C		ce 6 Other (Sp injury occurred	ecity)
	2 2 2 2	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - Albuilding, etc. (Spe	ocify)			С	City or Town, S	State)	Rural Route Number,
)	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basis of exam and manner stated.	ination and/or in	29c. Licer	opinion, de ise number 8079	eath occurred at	the time, date	and place, and di Date signed (Moi June 5,	ne to the cause(s)
7	5		30. Name and address of person who Francine A. Higgs	completed cause of death (I s-Shipman, M.	tem 23a) (Type, D. 1170	, Print)		Drive Be	eltsvi]		
	Sta Regist		31. Date filed (Month Day, Year)	2006 32. Resistrar's Sig	gnature	Coule					

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06-04010

Please Type or Print in Black Indelible Ink

illiam Bruce E	cha		Departme			Hygiene	0.1	
		Registrar	Certifica	ate of Death			g. No. 2	106 1954
Physici edical Exami		William Bruce Echard			=	2. Date of Death Month June 11, 2	Day Year 006	3. Time of Death 1035 hrs
		Facility Name (if not institution, give street and number) Southgate Avenue		4b. City, Town, o	r Location of Dea	ath	4c. County of Anne Aru	
Funeral			(In yrs. last birth		ar If Under 24H	Irs 8 Date of Birth		Birthplace (State or
Director		220-56-8535 1XM 2_F 53		Yrs. Months Da		May 2,		Foreign Country) Florida
any		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town of	or Location				10d. Inside City Limits
*	L	Maryland Anne Arundel	Anna	nolis				1 Yes 2 No
ne Maryland or 28a-f show fied at once.	cto	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	uneral Director	70 South gate Ave		21401				·
with the ns 23a be noti	Fra	70 Southgate Ave	ver in U.S.	13. Was Decedent of Hi	spanic Origin? (Specify Yes or No-	Jnited S 14. Race -	Cates American Indian, Black,
r death or iter must	-un-	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X	∑ No	If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	White,	etc.
after ral",	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2 X			Specify:	White
hours	ted	15. Decedent's Education (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+		Decedent's Usual Occupa furing most of working life	ation (Give kind o e. DO NOT use re	f work done etired)	16b. Kind of Busi	ness/Industry
36 nin 72 s than '	ple	Elementary/Secondary (0-12) College (1-4 or 5+	<i>'</i>	Welding	3		Self :	Employed
d with	Completed	17. Father's Name (First, Middle, Last)			18.Mother's Nan	ne (First, Middle, M		
215 be file ntal H rked e	Be (William Robert Echard			Marv K.	Clemens	,	
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after Department of Health and Montal Hygiene Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	2	19a Informant's Name/Relationship (Type, Print)	19b	. Mailing Address (Stre	et and Number of	Rural Route Numb	er, City or Town,	State, Zip Code)
MC slath ar aums		Mary K. Echard / Mother 20a Method of Disposition		70 Southgate	e Ave.	Annapolis Date	, Maryl	and 21401
of Hear tr		2 Wetnod of Disposition 1 Burial 2 X Cremation 3 Removal from State	cremato	f Disposition (Name of ce pry or other place)				
Page ment tant: or ot		4 Donation 5 Other Specify:	Fort I			/16/2006	Brentwo	ood, Maryland
Balt Sermit Separt mpor njury		21. Signature of Funeral Service Licensee		22. Name and Addres	3	ohn M. Ta	ylor Fur	neral Home, Inc
Physician		23a. Part I. Enter the disease, or complications that caused th	e death. Do not	1147 Duke of dving	f Glouc	ester St.	Annapo	olis MD 21401 Approximate Interval
/Medical		failure. List only one cause on each line.				or respiratory arres	it, shock, of fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) ATTIETOSCLETO Due to (or as a consequence of the condition resulting in death)		ovascular dise	ase			Death
and the same of th	L	Sequentially list conditions, b						
	ine	if any, leading to immediate Due to (or as a consequence of the Underlying Cauce	uence of):					
n :5	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the control of	ience of):					-
be executed ician and urial - transit	ial E	d		-			·	
ag ici	edical			erME,g857,7/27	/06 TT			
of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending physiciant director, page 2 should be detached for use as the b	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	of pregnancy	Fetal death 3	Ectopic pregr	nancv	23d. Date of de Month	livery Day Year
th cer	icia	past 12 months?	ne of death 5	Other (Specify)		ian ioy	World	Day Teal
Box he death c the atten hed for us	hys	1 Yes 2 No 9 Unknown 9 Unknown					<u> </u>	
P.O.	by	Part II. Other significant conditions contributing to death b	ut not resulting	in the underlying cause	given in Part I.			te to the cause of death?
ds, I			-			24a Was an		Probably 4 V Unknown
Sore law re has be 2 sho	Completed	·				autopsy	prio	re autopsy findings available r to completion of cause of
Re(The ficate	Co					1 Y Yes 2		Yes 2 No
ital iician s certi	Be	25. Was case referred to medical examiner? Hospital: Impatient	2 500		of Death (Check			
Division of Vital Records, and a Attending Physician: The law requires after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a by the funeral director, page 2 should	2	1 Ves 2 No lospital Inpatient 27. Manner of Death 28a. Date of Injury		tpatient 3 DOA	y at Work?	ng Home 5 Re	esidence 6 🗸 (Other: Scene
endin ath.	tion	1 X Natural 5 Pending (Month, Day,Year	,	1	res 2 No		.,.,	
ivision I or Attend after death Director: d in by the	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	y - At home, far	m, street, factory, office b	ouilding, etc.	28f. Location (Str	eet and Number of	or Rural Route Number, City
Division ospital or Attent hours after death uneral Director:	Certification:	4 Homicide determined (Specify)				or Town, Sta	te)	
e Hos 24 ho e Fun etely		29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, deat	h occurred at the time, da	ate and place, an	d due to the cause(s) and manner as	started.
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certi completely filled in by the funeral director	edical	one) 2 Medical Examiner: On the basis of examinand manner stated.	ation and/or inv			at the time, date an	d place, and due	to the cause(s)
_	Σ	29b. Signature and title of certifier		29c. Licens				(Month, Day, Year)
		Theodon M. Kig.	an	O.C.	VI.E.		June 12, 200	0
		30. Name and address of person who completed cause of ear Theodore King MD. Assistant Medical Exa		11 Penn Street, Ba	ltimore MD 1	21201		
	ate			r ein Gueet, ba	idinole, IVID 2	- 1201		
ગ	خلك	, , , , , , , , , , , , , , , , , , ,	La	A 00 .				i i

			epartment of Health and M Certificate of Death	ental Hygie	•	19549
Physic /Medi		Decedent's Name (First, Middle, Last) Fulton Robert Evans		2. Date of Death Month June	Day Year 2006	3. Time of Death 5:40 a M
Exami		4a. Facility Name (If not institution, give street and number) 407 Commerce Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	4b. City, Town, or Location of Death Hurlock favi If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death Dorche	
Funeral Director		220-03-0038	Months Days Hours Min	(Month, Day, Y		lace (State or Foreign htry) yland
ne Marylan 8a-f show	ector	10a. State 10b. County 10c. City, Town of MD Dorchester	r Location Cambridge		1	0d. Inside City Limits 1 188 Yes 2 □ No
s 23e or 2	Funeral Director	100 Choptank Ave.	10f. Zip Code 21613		. Citizen of What Coun	
be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "neturel", or Items 23e or 28e-1 show event, I're Modical Examilier must be multihad at	ğ	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Speiff Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify:	city Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: whi	etc.
within 72 h ene. than "netu	Completed	15. Decedent's Education (Specify only highest grade completed) (C) Elementary/Secondary (0-12) College (1-4or 5+)	acedent's Usual Occupation live kind of work done during most of working e. DO NOT use retired)		b. Kind of Business/Inc	,
al Hygi I other	To Be Co	10 17. Father's Name (First, Middle, Last) Fulton B. Evans	18. Mother's Name		,	rlor
	-	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rural Choptank Ave., Can	Route Number, C.	ity or Town, State, Zip	Code)
oermit. Pages 1 ar Department of Hea mportant: If item any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition	sposition (Name of Date of Crematory or other place)	ate 200	c. Location - City or To	
permit. Page Department of Important: if any injury or once.		21. Signature in Funeral Sarvice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not	22. Name and Address of Facility Tho 700 Locust St., Carr	mas Fune bridge,	ral Home, MD 21613	
Physician /Medical Examiner bulkician and provinging street principles of the princ	edical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	rie Lang Ci	AN CZ1		Interval Between Onset and Death Value 4 CA
that the death certifica ed by the attending ph detached for use as th	Physician/M		3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver Month	y Day Year
w requires that the been signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
The lay ate has page 2	Completed			24a. Was an autopsy performed	? prior to com death?	sy findings available pletion of cause of
ng Phye Iter this Ineral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	of 28c. Injury at 28		6 Other (Specify)	laughters home
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	il Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) 29a. Certifier 7 ☐ Certifying Physician: To the best of my knowledge determined		City or Town, St		
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	29c. License number	at the time, date a	Date signed (Month, Da	the cause(s)
			e, Print) ra St., Cambridge, M	21613		
Sta Registr		31. Date filed (Month, Day, Year) 5 2006 32. Registar's Signature	brook			

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		-	For Stete Registrar	State	of Marylar	•	artmen rtificate			and M		giene Reg. No.2	006	1	9550
			1. Decedent's Name (First, Mid	idle, Last)							2. Date of Dea Month	ath Day	Year	3. Tin	ne of Death
	Physici: /Medic		Minnie	Barbar	a	Faud	ree				June	3	2006	5:1	.5 p M
	Examin		4a. Facility Name (If not institut	ion, give street and i	number)		4b. City,	Town, or	Location of	of Death			ounty of Dea		
			1952 Severn					apo1		74 Hrs			Anne A		
П	Funeral		5. Social Security Number	6. Sex 1 □ M 2	7. Age (In yrs. 88		If Under Months	Days	If Under: Hours	Min.	B. Date of Birtl (Month, Day March 3	n / Year) 1 19		thplace (St ountry) rylan	tate or Foreign
	Director		214-18-9663 Usual Residence of Decedent								narch 5	1,17.	ro Ma	Гутан	u
	yland Now		10a. State 10b. Coun	•		ity, Town or Lo									de City Limits
	a-f s	ctor	MD Ann	e Arundel		Annapo	lis							10	Yes 2X No
	ith th	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Co	ountry?	
	s 23a	ie l	1952 Severn					214			4 14 14	144			
	er de Items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ M	12. Was D	ecedent Ever in U Forces? s 2 2 No	J.S. 13.	Was Deced If Yes, spec	ent of Hi offy Cuba	n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	14	4. Race - Am Black, Whi		ın,
36	Ir, or	by Funeral	3 XWidowed 4 ☐ Divorc	If Vac	Give r Dates:		1 Yes	2 X No	Specify:			5	Specify:	Whit	е
21215-0036	be filed within 72 hours after deeth with the Maryland tal Hyglene. d other then "naturel", or items 23a or 28a-f show event, the Medical Examinational templified at		15. Deced	lent's Education	-d1	16a. Dece	dent's Usua	I Occupa	ation	t of work	ina	16b. Kind	d of Business	Industry	
212	en "n	Completed	(Specify only nigital Elementary/Secondary (0-12	hest grade complete !) College	e (1-4or 5+)	1	kind of woi DO NOT us			OF WORK	ng		_		
7	Hygien Hygien ther th	S	3			Laun	dry S	ervi				Hote			
Maryland	0 = 0 \$	Be	17. Father's Name (First, Middle								<i>(First, Middl</i> e, rine Po		umame)		
څ	should be and Mental s marked o umatic eve	2	John Kirchn 19a. Informant's Name/Relatio			10h Mailie	ng Address	(Street			Al Route Numbe		Town State	Zin Codel	
B S	d 2 s th an trau	r I	Barbara Ann		(Daught		_								01
<u>ē</u>	Heal Hem		20a. Method of Disposition		20b.	Place of Dispo	sition (Nan	ne of			Date		ation - City or		
Ë	Page ient o nt: If ry or		1 ☐ Burial 2 XCrematio 4 ☐ Donation 5 ☐ Other		om State	tro Cr				6-6-	2006	Balt:	imore,	MD	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any njury or other traumatic e one.		21. Signature of Funeral Servi	ce lacensee	1	22	2. Name an	d Addres	s of Facilit	y 	Home I) A			
m	88 = 8		▶78- y.	Jun			_12_R	idge	ly Av	enue	Home, E	olis	, MD 2	1401	
			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that ist only one cause o	at caused the dea in each line.	ith. Do not ent	ter the mod	e of dyin	g, such as	cardiac (or respiratory ar	rest,			ximate al Between and Death
	Physician		Immediate Cause (Final disease or condition	-a CN	ATZ b	ge H	(eNA	rl	ta	i lu	re.			2	yaurs
	/Medical Examiner		resulting in death)	- Due	to (or as a conse	1 3		A	A					- 5	/
		70	Sequentially list conditions,	b. Nue	to (or as a conse		coina	JUL 1	4					D(1	yeurs,
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	< □		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								_ ′	,
Č,	be executed sicien and burial-transit	Exa	that initiated events resulting in death) Last	C. Due	to (or as a conse	quence of):									
760,	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	cal		d							·				
99	rtifica ng ph s as th	Med	IF FEMALE:								<u> </u>				
Вох	leath certific ettending pl	an/	23b. Was decedent pregnant in the past 12 months?	1 Liv	outcome of pregn re birth 2 □ Fet	al death 3	_Ectopic pr					23	3d. Date of de Month	elivery Day	Year
o O	the e	Physician/Med	1 ☐ Yes 2 🗷 No 9 ☐ Unknown		egnant at time of known	death 5L	Other (sp	ecify)						,	
٥.	res that the de signed by the e t be detached t		Part II. Other significant cond	litions contributing to	o death but not re	sulting in the u	inderlying c	ause giv	en in Part I.		23e. Did to	obacco us	e contribute t	o the cause	e of death?
Records,	uires sign lid be	d by	Congest	ve Hea	at 70	ri liev	ی				101	res 2	No 3□P	robably 4	4 □Unknown
<u>ဂ</u>	w require s been sign should t	Completed	Diffyste	AHA	27.00	edes	257				24a. Was		24b. Were a	utopsy find	lings available
E	The lay te has age 2	E										rmed?	prior to death? 1 🔲 Yes		n of cause of
<u>E</u>	ruffica	BeC	25. Was case referred to med	ical					26. Place	of Deat	n (Check only o	7.			
<u>></u>	Attending Physician: r death. sctor: After this certification of the funeral director.	10	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	☐Inpatient 2☐	☐ ER/Outpatie			40 140	rsing Ho	me 5 Resid	ience 6	□Other (Spe	ecify)	
Division of Vital	ing P		27. Manner of Death 1 Natural 5 ☐ Pen	iding (M	ate of Injury fonth, Day Year)	28b. Time o Injury		Bc. Injun Worl		-	28d. Describe h	now injury	occurred		
Sio	ttend death tor: /	cati	2 Accident	estigation ald not be	and of lainer. At h	form of	M da ata a		Yes 2		28f. Location (S	Stroot and	Numberor	Pura / Pouto	Alumbos
\leq	efter of Direct In by	Certification;	4 Homicide dete	ermined 286. Pic	ace of Injury - At I uilding, etc. (Spec	ify)	reet, ractory	, опісе			City or Ton		Number of h	urar House	rvantber,
	spital		29a. Certifier	lying Physicien: To	the best of my kn	owledge, deat	th occurred	at the tin	ne, date an	d place,	and due to the	cause(s) a	nd manner a	s stated.	
	To the Hospital or Attending Physician: The within 24 hours elter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medic	cal Examinar: On the	basis of examin	ation and/or in	vestigation	, in my o	pinion, dea	th occur	red at the time,	date and p	lace, and du	e to the cau	use(s)
	To	Σ	29b. Signature and title of cert	ifier)		11/			e number	~ ~	1	29d. Date	signed (Mon	th, Day, Ye	ar)
)			Mules	1: leck	emo 1	MS	D	-00	561	50)	JU	ne 6	, de	06.
			30. Name and address of pers					Ç., 4.	ا1 م) A	nnene14	e Mer) 21/0	1	
	Sta	ate.	Charles Ad	nar) 32	2029 Registrar's Sign		wau,	5u1	LE 11.	۷, A	nnapoli:	o, MIL	, 2140	L	
	Regist			6 2006	Deser.	K A	all .	1							

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State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Day 3, 2006 6:15 A M Mildred Forrest **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brooke Grove Nursing and Rehab Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2 Months Days Hours Min. Yrs. May 26, 1922 OH Director 101-14-9375 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or items 23e or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD Montgomery Sandy Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18131 Slade School Road 20860 USA death v Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black, White, et filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than 12 Own Home mit. Pages 1 and 2 should be filed w partment of Heelith and Mental Hygier portant: if them 27 is marked other the hy injury or other traumatic event, the Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah Servetta Jacob Freed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6529 Hitt Avenue McLean VA 22101 Robert A. Forrest - Son Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 6/6/06 permit. Page Department o important: if any injury or once. Olney MD 21. Signature of Funeral Survice Licenses 22. Name and Address of Facility Danzansky-Godlberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Heart Failure Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of):
Aortic Stenosis Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Atherosclerotic Heart Disease ed by the attending physicien end detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Cher (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 QUnknown Diabetes Mellitus should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → 10 24a. Was an page 2 autopsy performed? has this certificate 2 (XNO 1 ☐ Yes director. 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident i Director: d in by the the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours efter of To the Funeral Direc completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D050545 June 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Golswill 0. Okoji MD 7513 New Hampshire Avenue Takoma Park MD 20912 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 JUN Registrar

Physici	an	1. Decedent's Name (First, Middle, Last)	ricate of Death	Reg. No. Date of Death Month Day Year A 3. Time of Death
/Medic		EDGAR S. FREEM		05 30 2006 CU 30 4c. County of Death
Examir	er	, and the same in	4b. City, Town, or Location of Death Pasadena	Anne Arundel
Turneyal.	-31			Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)
Funeral Director		569-44-2346 1		Jun 25, 1928 Maryland
Mot		10a. State 10b. County 10c. City, Town or Local		10d. Inside City Lim
in parties	Director	MD Anne Arundel Severna F		1 ☐ Yes 2 🖾
1 or 28	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country? USA
234	era	13 Admiral Road 11 Marital Status 12, Was Decedent Ever in U.S. 13, Was Decedent Ever in U.S. 14, Was Decedent Ever in U.S. 13, Was Decedent Ever in U.S. 14, Was Decedent Ever in U.S. 15, Was Decedent Ever in U.S. 15, Was Decedent Ever in U.S. 15, Was Decedent Ever in U.S. 16, Was Decedent Ever in U.S. 16, Was Decedent Ever in U.S. 16, Was Decedent Ever in U.S. 17, Was Decedent Ever in U.S. 1	21146 as Decedent of Hispanic Origin? (Specify	
Hygiene. uther than "naturel", or Iteme 23a or 28e-f ehow ont, I're Medical Exercities roual be ricillised at	by Funeral	1 □ Never Married 25 Married 15 Yes 2 □ No 1946 -	as Decedent of Hispanic Origin? (Specify res, specify Cuban, Mexican, Puerto Ric Yes 2 X No Specify:	sán, etc.) Black, White, etc. Specify: White
ical E		15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kn	nt's Usual Occupation	16b. Kind of Business/Industry
r than "r Ine Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Tru	nd of work done during most of working DNOT use retired) ack Driver	Transportation
la b	To Be C	17. Father's Name (First, Middle, Last) Edgar Strong Freeman, Jr.	18. Mother's Name (F Fredrica	First, Middle, Maiden Sumame) Hoffman
and Es m				Route Number, City or Town, State, Zip Code)
item 27 other tr		20a Method of Disposition 20b. Place of Disposit		verna Park, MD 21146 20c. Location - City or Town, State
		cemetery, crema	tion (Name of tatory or other place) ns Cemetery 2006	Crownsville, MD
Department of Important: If any injury or ones.		21 Six at the of Film of Service License 22	Name and Address of Facility Cranco & Sons, P.A.	. Severna Park Funeral Ho Severna Park, MD 21146
hysician Medical Xaminer e priial-transit	cal Examiner	disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		3 Years
ite has been signed by the ettending physi page 2 should be detached for use as the t	Physician/Medic		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
been signed t	þ	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
r this certificate has bee	Completed			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Name Name Name Name Name Name Name Name
ertific actor,	Be	25. Was case referred to medical examiner?	26. Place of Death (C	1
this certific	2	1 Pes 2 RevOutpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		d. Describe how injury occurred
r death. ector: After by the fune	atlon	1 Naturaf 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
o it	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, stree building, etc. (Specify)	et, factory, office 28f	f. Location (Street and Number or Rural Route Number, City or Town, State)
after Direct	O	29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or inve		
24 hours after Funeral Directed letely filled in by	dical	one) and manner stated.	estigation, in my opinion, death occurred	
within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	Medical	29b. Signature and title of certifier After Haus	29c. License number D 2 1 4 3	29d. Date signed (Month, Day, Year) 38 ANY BUB HWAY ANN POLISM D214

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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			- For State egistrar				Certifi	icate of	Death	1				Reg. No.	6-	UU	יננו טי	
Physic	cian	n/ 1 Decedent's Name (First, Middle,Last) er Mary Anna FLOOK											Date of De		Year		3. Time of Death	
edical Exan	nine	er	Mary Anna FLO	OK									Month June 10,	2006	Teal		0840 hrs	
		4	a. Facility Name (if not institution	n, give st	reet and n	umber)		4	b. City, To	own, or Le	ocation of D	Death		4c. (County of	Death		
			4411 Philadelphia Roa	ad					Abing	don				Ha	arford			
-			Social Security Number	6. Sex		7 Age (In yrs. last b	outhday)	If Unde	r 1 Year	If Under 2	4Hrs 8	Date of B	Birth (MM/D	D/YYYYY	9 Birt	hplace (State or	
Funera Directo			- '					on throat y	Months			Min					n Maryland	
Directo	4		219-60-4262	1 M	2 <u>X</u> F	5	2	Yrs.		1			Dec.	29,19	953	Cou	intry)	
	1	Ţ	Jsual Residence of Decedent															
any	-		10a State 10b. County			10	c. City, Tov	wn or Location	on								10d Inside City Limits	
ld how	, اي	_ [:	Maryland Har	ford	l	1		Abin	gdon								1 Yes 2 No	
Aaryland 28a-f show		읽는	10e. Street and Number			1			10f. Zip	Code				10g. Citize	en of Wha	it Cour	itry?	
Ma rr 28		ā I	4411 Philadelph	nia F	Road						1001		- 1	-	JSA		•	
h the																		
ms 2	20	杰 I	11. Marital Status		2. Was De Armed F		er in U.S.				anic Origin? Mexican, Pu			lo- 1	Race - White,		can Indian, Black,	
death r ite	in i	\$	1 Never Married 2 Ma	arried 1	Yes	-	No	" "	oo, opoon,	, ouban,	Working City	40.10	, oto.)					
fter (- II L	-	3 Widowed 4 X Div	orced If	es, Give Ye	аг		1	Yes 2	ΧNο	specify:			s	Specify:	wh	nite	
hours afte natural",		<u></u>	15. Decedent's Education (Spec	cify only l	nighest gra	de compl	eted) 16	a. Decedent						16b. Kii	nd of Busi	iness/li	ndustry	
2 ho		leted	Elementary/Secondary (0-12)		College (1-4 or 5+)		during mo	ost of work	king lite. L	DO NOT use	e retired))					
36 iin 7 ihan		اقِ	12		6			accou	nting	g/boo	okkeer	per	er various businesses					
215-0036 be filed within 7 ntal Hygiene. riked other than		dwo-	17. Father's Name (First, Middle,	Last)	-		1_	-			B.Mother's N	Name (Fi	rst. Middle	. Maiden S	urname)			
Filed Hys		91	John Richard	,	or							Elsie Jane unknown						
21215-0036 Id be filed within 72 Aental Hygiene. marked other than '	E C	8	19a. Informant's Name/Relations					10h Mailine	Addross	(Ctroot		LISIE Jane unknown Der or Rural Route Number, City or Town, State, Zip Code)					Zin Cada	
21 hould nd Me is ma	E	2					l	_										
MD d 2 sho lith and n 27 is	traumatic	_	J. R. Miller -	- pro	tner								Hagerstown, Maryland 21740 Date 20c. Location - City or Town, State					
Titer Hea	=	1	20a Method of Disposition	2	Damaral	irom Ctata		e of Disposi natory or oth		e of cem	etery,	D	ate	20c. Lo	ocation - (City or	Town, State	
altimore, mit. Pages I at partment of He	9	1 X Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 4 Donation 5 Other Specify:										6/15	5/06	Воо	nsbo	ro,	Maryland	
t. Pa	5	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility												_1				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: (Fire Z7 is marked other than "matural", or items 23a or 28a-f sho	ınînı												MINNICH FUNERAL HOME d., Hagerstown, Md. 21740					
		4	23a. Part I. Enter the disease, or				- de de De	41	5 E.	WILE	son Bl	LVd.	, наg	ersto	wn,	Ma.		
Physicia		-	23a. Hart I. Enter the disease, or failure. List only one cause			caused th	e death. Do	not enter tr	ne mode d	r ayırıg, s	uch as card	alac or re	spiratory a	rrest, snoc	k, or near	l	Approximate Interval Between Onset and	
Medica			Immediate Cause (Final disease	: a.	Acute	alcol	nol int	coxicat	ion								Death	
Examine	31		or condition resulting in death)	_	e to (or as	a consequ	uence of):											
1			Sequentially list conditions,	b.														
		힐	if any, leading to immediate		e to (or as	a conseq	uence of):											
	٠,		(Disease or injury that initiated	C														
- 1		Exa	events resulting in death) Last	Du	e to (or as	a consequ	uence of):											
cuted	tran			_ d														
8760, rificate be executed ng physician and	<u> </u>	n/Medical	X UNPENDED		MENDED	item#	#23a,27	7,28a-f	,perME	,g856	, 6/30/0	06 TT						
8760, tifficate be ng physic	e pri	ĕ⊦	IF FEMALE:		23c. If yes	, outcome	of pregnan	lcy						23d.	Date of d	lelivery		
87 tiffica	as th	<u>ء</u> اڃَ	23b. Was decedent pregnant in the	he	1 Live	birth		₂ Fe	tal death	3	Ectopic p	regnancy	Y	1	vlonth		ay Year	
ondi	nse	- <u>B</u> -	past 12 months?	- 1	4 Preg	nant at tir	me of death	5 Ot	her (Spec	cify)				16				
Box 68 ne death cert the attendir	1 for	Physicia	1 Yes 2 No 9 🗸 Un	known	9 Unk	nown												
C. I	che	둡ㅏ	Part II. Other significant condit	tions co	ontributing	to death b	out not resu	Iting in the L	ınderlying	cause gi	ven in Part I	I.	23e Did	tobacco u	se contrib	ute to	the cause of death?	
P.O.	g det	<u>اھ</u>											1 Y	es 2	No 3	Prob	ably 4 🗸 Unknown	
cords, P.O. law requires that the has been signed by	ld b	<u></u>											24a. Wa	s an	24h W	ere au	topsy findings available	
y rec	shor	흥										_	aut	opsy	pri	ior to c	ompletion of cause of	
e lay	24a. Was an autopsy performed? 1 ✓ Yes 2 No									eath? ✔ Ye	s 2 No							
ifica			25 Was case referred to medica	J						26 Place	of Death (Cl	heck only						
of Vital Recing Physician: The After this certificate	rector,	a	examiner?	_	pital:	Inpatient	م ال	R/Outpatient			Whor:		Home 5	Posidos	ce 6 🗸	Othor	· Coopo	
Phys C		유	1 Yes 2 No		lon. D.	·		Bb. Time of I			. []						, ocerie	
Ing I	<u>₩</u>		27. Manner of Death			e of Injury th, Day,Yea	er)	SD. Time of I	njury		y at Work?		a. Describ	e how injur	y occurre	a		
eath.	the f	쓅		ding stigation	Fnd 6	/9/200	06 Fr	nd 8:28	am	1 Y	es 2X N		unknow					
Division of Vital Records, spital or Attending Physician: The law requir hours after death.	filled in by	Certification:	W	ild not be	28e. Pla	ace of Inju	ry - At home	e, farm, stre	et, factory	office bu	ulding, etc.	28	f. Location	(Street an	d Number	r or Ru	ral Route Number, City lelphia Rd.	
talo	led i	핉		ermined	(Specif	v) (other-s	cene				Ab:	ingdon	, State) 44 MD	411 PF	ша	иетрила ка.	
on bi	>	- 1	29a. Certifier 1 Cortifuing P	hveisiaa	. To the h				red at the	time dat	te and place				l manner s	as start	red	
he II in 24 he Fi	olete	S	(Check only one) 2 ✓ Medical Exa															
To the Ho within 24 To the Fu	completely	Medical	2	а	nd manner													
		≥	29b. Signature and title of certifi	er	-	_	1		290	. License							nth, Day, Year)	
	O.C.M.E. June 11, 2006																	
		ŀ	30. Name and address of person	n who col	npleted ca	use of dea	ath (Item 23	ia)										
					ant Med			111 Pen	n Stree	t, Baltii	more, MI	D 2120)1					
						2	s Signature	-	- 00					_				
		ate	31. Date filed (Month, Day, Year)	2008		MA AME	, 1	GOS										
Reg	riet																	

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2006 11:15 .Tune Emma F. Fontana /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Spring
If Under 24 Hrs. Silver nder 1 Year Montgomery 3510 Napier Street Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, 5. Social Security Number **Funeral** Days Months Hours 1 ☐ M 2 🖸 F May 31, 1914 Italy Director 92 578-64-6554 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 show the Medical Examinar mest be notified at 1 ☐ Yes 2 ☑ No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 20906 Italy 3510 Napier Street death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) Printing Bindery Clerk 8 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event once. Be Teresa Zuca1 Giovanni Detassis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3510 Napier Street Silver Spring, Maryland 20906 Daughter Itala Fontana 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Mount Olivet Cemetery Jun. 7, 2006 Washington, DC 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licenses 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 months Physician a Cerebral Vascular Accidents disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diffuse Vascular Disease vears Sequentially list conditions, if any, leading to the leading cause. Enter Underlying Cause (Disease or injury Due to (or as a cons uence of): Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 88 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No Records, P.O. 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) After thi funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 1 Xcartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier Daw edra marthe June 5, 2006 D 41173 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Avenue #301 Silver Spring, MD 20902 M.D. Martha S. Saavedra, Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 JUN Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5 2006 June Margaret Atwood Fisher 10:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4601 Merivale Road Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Mar 29 1911 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕏 F 95 Massachusetts 578-36-6024 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ortant: If item 27 is marked other than "natural", or items 23s or 28s-1 show injury or other traumatic event, the Medical Examinar must be notified at it. 1 Yes 2 □ No Director MD Montgomery Chevy Chase the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4601 Merivale Road 20815 United States death Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Commercial al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Real Estate 5+ 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be and Mental ! Abel Wilson Atwood Iza Skelton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 173 Oldefield Farms / Enfield Connecticut 06082 John Fisher / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State June 7,2006 Falls Church , VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave NW Washington DC 20016 lunar Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Malignancy -unknown origin Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ History of Colon Cancer, status post colostomy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s this certificate : After this certifice tuneral director, i Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Inpatient ္ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 1 ⊠Natural 2 ☐ Accident 5 Pending within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35579 June 5, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller MD 6844 Tulip Hill Terrace Bethesda, MD 20816 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylar	-	artment of H rtificate of L		Mental Hy	ygienę Reg. Nd	006	1955	5
	BL 1333		1. Decedent's Name (First, Middle	, Last)					2. Date of D Month	eath Day	Year	3. Time of Death	h
	Physicia /Medic		Kenneth Neil	Fincham	.Sr.				June :		06	0400	М
100	Examin	er	 Facility Name (If not institution). 	, give street and no	umber)		4b. City, Town, or	Location of Death		4c. C	county of Dea	ith	
			807 Young Ct. 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday	Westmir If Under 1 Year	ister If Under 24 Hrs.	8. Date of B		arrol		-/
N. Carlot	Funeral Director		216-28-1879	1 2 M 2 □ F	1. Age (III yis.	73 Yrs.	Months Days	Hours Min.	Nov 0	9 193	2	thplace (State or Fore ountry) MD	sign
	pu .		Usual Residence of Decedent		10-0	-						T	
	filed within 72 hours after death with the Maryland Hygiene. that than "netural", or Itame 23a or 28a-f show int, the Medical Examinat must be notified at	tor	MD 10b. County	arroll	10c. CI	ity, Town or Lo	estminste	r				10d. Inside City Lim	_
	th the or 28s	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citize	on of What C	ountry?	
	ath wi	ral	807 Young Ct				21	158			USA		
	er des	nne	11. Marital Status	Armed F	cedent Ever in L		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or N Rican, etc.)	10- 14	Black, Whi	erican Indian, le, etc.	
36	irs aft	by F	1 Never Married 2 X Marri 3 Widowed 4 Divorced	led 1 XYes If Yes, G Year or I	2 No 19	45	1 ☐ Yes 2 ☑ No	Specify:		s	Specify:	White	
Š	2 hou	ted	15. Decedeni			16a. Dece	dent's Usual Occupa	ation		16b. Kind	d of Business	/Industry	
21215-0036	thin 7 e.	Completed	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done of DO NOT use retired,)	ang				
7	ed wi	Con	7				Superviso				nitati	on	
Maryland	d be findal Hed of	Be	17. Father's Name (First, Middle, I Lester Fincham	•				18. Mother's Nam	e (First, Middle Dumhear		u <i>mame)</i>		
Ë	should nd Me mark matic	ဥ	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street a				Town State	Zin Code)	
	nd 2 still ar ar ar trau		Bettie Fincham				7 Young C		inster,		21158		
ē,	s 1 a of Hez Item othe		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other place	6/12	72006	+	ation - City or	Town, Slate	
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🖾 Other (Sp	3 □Removal from Decity)MausOl	eum Ev	ergree	n Memoria	í Garden	S	Fin	Finksburg, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Itame 23s or 28a-f show any injury or other traumatic event, the Madical Examinating must be notified at once.		21. Signature of Juneral Service	icen ee		22 A 1	. Name and Addres	s of Facility Pri	tts Fur	neral	Home 8	Chapel, 1	PA
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dear	th. Do not ent	2 Washing or the mode of dying	g, such as cardiac	or respiratory	arrest,	<u> </u>	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			,	1					Onset and Death	
	/Medical		resulting in death)		(or as a consec		LUNG	Cinca					
	Examiner		Sequentially list conditions,	ism L	orgny	<i>'</i> ,							
	pe sis	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quanca of).							
	and and II-tran	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									_		
8760,	cate be executed physicien and the burial-transit	d d											
9	ifficate g phy as the	edlo		0.									
Вох	h cert endin	an/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn. birth 2 ☐ Feta		Ectopic pregnancy			23	d. Date of de	livery	
о. П	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of o		Other (specify)				Month	Day Year	
۵,	that the od by detac	Ph	Part II. Other significant conditio	ns contributing to d	death but not res	sulting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use	contribute to	the cause of death?	
Vital Records,	89 G 99	d by	Congress	Artury	0-5-	ددور			10	Yes 2 🗆	No 3∏P	robably 4 Dunknow	wn
00	aw requir as been si 2 should	Completed	·	•					24a. Was	s an	24b. Were a	utopsy findings availal	ble
æ	The lar	E O								ormed?	phor to death?	comptetion of cause of	of
ita		BeC	25. Was case referred to medical examiner?					26. Place of Deat				32 110	-
	Physic this ce al dire	ဥ	1 Yes 2 No			ER/Outpatien		4 Nursing no	me 5 Res	idence 6 [Other (Spe	cify)	
Division of	Attending Physician: or death. ector: After this certific by the funeral director.	ü	27. Manner of Death 1. Natural 5 ☐ Pending	9	of Injury oth, Day Year)	28b. Time of Injury	Work		28d. Describe	how injury	occurred		
Sic	death death stor: / the f	Icat	2 Accident investig 3 Suicide 6 Could n	ot be 290 Plac	a of Injury - Ath	ome form ele	M 1 1	′es 2 □No	28f Location	(Street and	Number or O	ural Route Number.	
Ď.	after after Dire	Certification:	4 Homicide determi	build	ling, etc. (Specia	fy)	eet, ractory, onice		City or To	wn, State)	*umber or m	arar nodie warmer,	
	ospite hours unera ly fille		29a. Certifier (Check only 2 Medical E	g Physician: To th	e best of my kno	owledge, death	occurred at the tim	e, date and place,	and due to the	cause(s) ar	nd manner as	s stated.	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical	onej	and mar	ner stated.	ation and/or in	vestigation, in my op		ied at the time,				
		~	29b. Signature and title of certifier				29c. License	number		29d. Date :	signed (Mont	h, Day, Year)	
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	114		30. Name and address of person v			randacis took, that y land							
	LU WIT					e						0 /12 2	
Ġ.	Sta	te	31. Date filed (Month, Day, Year) JUN 1		gistrar's Signa	S 3 L Co	CV	Cecr	+ Ro	100		21133	

			1 - For State Registrar	State of Ma			artment of F <i>rtificate of</i>		Mental H	reg. N	COU)6	19557
	Physici /Medio		1. Decedent's Name (First, Middle, L ${f Florence}$	Louise		God	elz		2. Date of I Month May		ay 20	Year 106	3. Time of Death 1:00 p M
	Examir Funeral			Nursing H	e (In yrs. last birt		4b. City, Town, o Millers If Under 1 Year Months Days		8. Date of E	3irth Day, Yea	ir)	Aru	
	Director		577-20-0282 Usual Residence of Decedent	1 M 2 D 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Yrs.			Sept.	3,	1907	I11:	inois
	Marylau i-f show	ţō	10a. State 10b. County MD Anne A	rundel	10c. City, Town	-						1	0d. Inside City Limits 1 □ Yes 2XXNo
	th the	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of V	Vhat Cour	ntry?
	ath wi	rai	899 Cecil Avenu				2110				USA		
980	urs after de al', or Item	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 Yes 2221 If Yes, Give Year or Dates:	Ever in U.S. No		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 X No	ispanic Origin? (in, Mexican, Puel Specify:	Specify Yes or find the Rican, etc.)	No-		k, White,	an Indian, etc. nite
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Iteme 23e or 28e-1 show any injury or other traumatic event, I'm Medical Exacting raisel be inclified at ODGe.	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5	i+) _	(Give life. L	lent's Usual Occup kind of work done OO NOT use retired	during most of wo	orking		Kind of Bu	isiness/Ind	dustry
i O	filled v Hygie other t	O C	12 17. Father's Name (First, Middle, Las	it)	Se	cre	etary	18. Mother's Na	me (First, Midd	CE lle, Maide		e)	
<u>lan</u>	Mental Mental rked c	To Be	Austin Meade Kr	emkau					elyn Ra				
lar	2 short and N is ma	•	19a. Informant's Name/Relationship				g Address (Street	and Number or R	ural Route Num	ber, City	or Town,		Code)
e,	1 and Health em 27 ther ti		Ralph E. Mayer	(Nephew)			Iyway La sition (Name of	ne, Ches	tertown Date				um State
Baltimore,	Pages nent of ent: If it		1 ☐ Burial 2 🛣 Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		cemeter	y, cren	natory or other place ematory	- 1	2-2006				
Balt	permit. Departnimporte any inju		21. Signature of Funeral Service Lio	ensee		22	Name and Address Hardesty 851 Anna	ss of Facility Funeral	Home.	P.A.			
	Physician and physician as the purial-transit	al Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ATHER Due to (or as: Due to (or as:	ne.	2.6 7 of):					15 FA 5	:E	Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	2 Fetel death		Ectopic pregnancy Other (specify)						
rds, P	quires that n signed b uld be deta	d by P	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the un	derlying cause give	en in Part I.					
Vital Records,	The law recate has bee page 2 shor	Completed							24a. Wa aut per 1 □ Yes	opsy formed?	P	rior to con eath?	rpletion of cause of
VIta	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital			104	26. Place of De	ath (Check only	one)			
DIVISION OF	Attending Physician: The laving death. sector: After this certificate has by the funeral director, page 2	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie	y 28b. Ti	<u> </u>	28c. Injun Work	4 Nursing F			altimore, MD A. ills, MD 21054 Approximate Interval Between Onset and Death VEACS 23d. Date of delivery Month Day Year according to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No No No 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 30d? 31 Yes 2 No 31 Yes 2 No 32 No No 33 No No No 34 No No No 35 No No No 36 No No No 36 No No No 37 No No No 38 No No No 38 No No No 39 No No No 30 No No No 30 No No No 31 No No No 32 No No 34 No No No 35 No No No 36 No No No 36 No No No 37 No No No 38 No No No 38 No No No 39 No No No 30 No No 30 No No No 30 No No No 30 No No 30 No No No 30 No No No 30 No No 30 No No No 30 No 30 No No		
DIVIS	5 # 15 E	Certification;	3 Suicide 6 Could not determined	28e. Place of Injubulding, etc	iry - At home, fari c. (Specify)	m, stre	eet, factory, office		28f. Location City or To	(Street a	ind Numbe	er or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funerel Director Completely filled in the Funerel Complete	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and	death Vor inv	occurred at the timestigation, in my of	e, date and place pinion, death occu	e, and due to the urred at the time	e cause(s e, date an	s) and mar nd place, a	nner as sta	ated. the cause(s)
	To the Hospital within 24 hours a To the Funerel Completely filled	29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature							29d. Da	ate signed	(Month, E	Day, Year)	
	- 1	-	30. Name and address of person who	completed cause of de	ath (Item 22a) (7	Type "	Print)	31136		MI	7 3/	20	066
	Sta Registr		BRIAS C. 31. Date filed (Month, Day, Year)	MACLAC	G; MO	,9	005 KC	LBRI	DE RO,	BA	FIM	ORC	pm) 21236

John Andrew Gommengenger
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1	For State	State of Maryland /	Departn			ntal Hygi		06	19558
Physician		Registrar 1. Decedent's Name (First, Middle, Last) John Andrew Gomme	ngenger		, , , , , , , , , , , , , , , , , , ,		Date of Death Month	Day	Year SG	3. Time of Death 12.30P M
/Medical Examiner		la. Facility Name (If not institution, give st Doctor's Community	reet and number) Hospital	4b.	City, Town, or Location o Lanham		· · · · · · · · · · · · · · · · · · ·		nty of Death	eorge's
Funeral Director		6. Sex 181–32–2161 6. Sex	7. Age (In yrs. last b		Inder 1 Year If Under 1 https://doi.org/10.1009/10.100	Min.	Date of Birth (Month, Day, une 20	rear) , 1920	9. Birth Cou	place (State or Foreign intry) W York
faryland show	2	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo	orge's		chellville			,		10d. Inside City Limits 1 ☐ Yes 2 🖁 No
death with the Maryland ims 23e or 28e-f show remails a rediffed at movel Director		10e. Street and Number 10450 Lottsford Road	d 4-37 Creight		f. Zip Code 20721		10		of What Cou	intry?
urs after bl', or its	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1941–62		Decedent of Hispanic Original Specify Cuban, Mexican es 2X No Specify:		y Yes or No- an, etc.)		lack, White	ican Indian, , etc. nite
ed within 72 hours atter ygiene. rer than "natural", or ite r. tre Medical Examine		15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind life. DO N	Usual Occupation of work done during most OT use retired)		1	6b. Kind of	Business/li	
on tal Hygier the control of the con		17. Father's Name (First, Middle, Last) Roman Gommengenger	5+	Dd			First, Middle, M	aiden Sum		
nd 2 should the and Mentality is marken traumatic		19a. Informant's Name/Relationship <i>(Typ</i> Kristin Colligan/d			dress (Street and Number lington Blve					
permit. Pages 1 an Department of Heali Important: if Item 2 any Injury or other once.		20a. Method of Disposition 1 ★★urial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b. Place cemet	of Disposition tery, cremator lallows	(Name of y or other place) Cemetery	Date 6/7/20				Town, State le, Maryland
permit. Departm imports any inju		21. Signature of Foneral Service License	diller	147	ne and Address of Facilit Duke of Glo	uceste	er St.,	Annaj		
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	CONCENTIVE	e He	ande of dying, such as	cardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
Examiner	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury	Due to (or as a consequence	eval	FAILURE	3				5 Days
le be executed ysician and e burial-transit	cal Evalilli	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence		loma_					Lyears
nat the death certificate to by the attending physic etached for use as the total control of the state of the total of the state of the total of the state of the total of the state of the	iciai viviedi	in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		ppic pregnancy er (specify)				Date of deliment	very Day Year
res that the de igned by the a	2	9 ☐ Unknown Part II. Other significant conditions con		g in the under	ying cause given in Part I		23e. Did tob	1		the cause of death?
The law requir sate has been si page 2 should	naialdino	TDEFILIA.					24a. Was an autopsy perion	24	b. Were au	topsy findings available completion of cause of
hysician this certifical	0 0	25. Was case referred to medical examiner? 1 Yes 2 No 27. Nanner of Death 1 Natural 5 Pending investigation		Outpatient 3 D. Time of Injury	DOA Other: 4 Nu	ursing Home	5 Resider	nce 6 🗆 0		Sify)
s after des	Certification.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street,	actory, office	28f	Location (Str City or Town	eet and Nu State)	mber or Ru	ral Route Number,
the Hospii in 24 hour the Funer ipletely fill	edical	(Check only 2 Medical Examinone)	ician: To the best of my knowled ler: On the basis of examination and manner stated.	dge, death occ and/or investi	gation, in my opinion, dea	nd place, and ath occurred	at the time, da	te and plac	e, and due	to the cause(s)
To To	Σ	29b. Signature and title of ceptifier	uo		29c. License number	03		ume sig	4/	2006
		30. Name and address of person who op 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a ABCAGE) WAD Registrar's Signature	400	o Mitche	llujt	Le Rd	1321	6 k	Duci, MI)
Stat Registra	_	JUN 0 6 2006		Breek						Je116

		-	1 - State of State of Registrar		artment of Health rtificate of Death	and Mental Hygiei 1 Reg.	2000	19559
. 4	Physicia		1. Decedent's Name (First, Middle, Last) GLiRA LOUIS	E GROS	SSMAN		Day Year	3. Time of Death 18 30 M
	/Medic Examin		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location		4c. County of Death	(0)
4 10	LAGITIII		Kris Leigh Assisted Liv	ing	Severna 1		Anne Aru	
1400	Funeral Director		5. Social Security Number 6. Sex 1 M 2 SE	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of Birth (Month, Day, Ye) July 14,		lace (State or Foreign try) York
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10	0d. Inside City Limits
	a-fah	ctor	MD Anne Arundel	Annapo	lis			1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
	s 23a	rai	680 Americana Drive	dent Ever in U.S. 13.	21403	rigin? (Specify Yes or No-	USA 14. Race - America	an Indian.
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Francian must be notified at ances.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decer Armed For 1 □ Yes If Yes, Give Year or Da	XXNo	Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 ☐ Yes 2 X No Specify		Black, White, o	
21215-003	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	o. Kind of Business/Inc	lustry
121	iene.	ошо	Elementary/Secondary (0-12) College (1-12)	4or 5+)	maker		Own Home	
	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)		18. Moth	ner's Name (First, Middle, Maid	den Sumame)	
ylar	Menta	10	David Gottlieb			nna Gottlieb		
Maryland	2 short and lam.	/ P	19a. Informant's Name/Relationship (Type, Print)	3		ber or Rural Route Number, Ci		Code)
	1 and Health em 27 ther t		Sandra G. Gimelstob (Dau 20a. Method of Disposition	20b. Place of Disp	osition (Name of	d, Arnold, MD Date 200	ZIUIZ c. Location - City or To	wn, State
nor	ages ant of nt: If It		1 X Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	state	matory or other place) st Cemetery	6-8-2006 A	nnapolis,	MD
Baltimore,	permit. P Departme Importar any injur		21. Signature of Funeral Service Lipensee		2. Name and Address of Faci Hardesty Fui		Α.	
			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	aused the death. Do not en				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	oure Res	puratary &	alun		Onset and Death
П	/Medical Examiner		resulting in death) Due to (or as a consequence of):	incelor de	(1 sorly 1	7 aprin	1 tons
	·	ē		or as a consequence of):	orcar o p	John C	Coure	J
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
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38760,	cate b physic the b	dical	d					
.O. Box 6	death certii ie ettending ad for use a	Physician/Me	230. Was decedent pregnant 1 Live bi	ant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
۵	8 50	þ	Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause given in Parl		cco use contribute to the	,
Records,	e law has b je 2 s	ompleted				24a. Was an autopsy performer	prior to cor d? death?	psy findings available impletion of cause of
Vital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?			ce of Death Check only one		4
of V	Physician: r this certific ral director,	၉	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ I	npatient 2 ER/Outpatie		Nursing Home 5 Residence 28d. Describe how		カント
uc	Jing After fune	ton:	Natural 3 Femiling	of Injury h, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 [injury occurred	
Division	or Atten ifter dea Director in by the	Certification:	3 Suicide 6 Could not be	of Injury - At home, farm, s ng, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,
	Hospital 24 hours a Funeral i	edical C	29a. Certifier Certifying Physician: To the (Check only one) 2 Medical Examiner: On the band mann	best of my knowledge, dea asis of examination and/or i ner stated.	th occurred at the time, date anvestigation, in my opinion, de	and place, and due to the cause eath occurred at the time, date	se(s) and manner as so and place, and due to	tated. the cause(s)
\	To the within 2 To the complet	Me	29b. Signature and title of certifier	Agus	29c. License numbe	1438 1	Date signed (Month,	Day, Year)
			30 Name and address of person will complete comp	e of death (Item 23a) (Type	Print DEFENS	SE HIGHWAY	ANNAPOLO	MOZIYU.
1	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 0 6 2006	egistrar's Signature	not .			

State of Maryland / Department of Health and Mental Hygiene 2 19560 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2006 June 16, **Physician** Margaret Agnes Goldsborough /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. July 23, 1940 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F 65 Director 215-38-4473 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland 1 St. Mary's Hollywood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 44569 Clarks Landing Road 20636 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. iled within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Owner / Operator School School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) jes 1 and 2 should be fill of Health and Mental H Be Charles A. Graves Mary Frances Alvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Joseph Charles Goldsborough/ Husband 44569 Clarks Landing Road, Hollywood, Maryland 20636 20a. Method of Disposition

1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot June 2006 Charles Memorial Gardens * 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20050 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 065truction Bowel Physician /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consumence off sician and burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Rena 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown urinos Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No autopsy performed? page congestive 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Maturai 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date, signed (Month, Day, Year) D52815 lexande 6/16/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Alexander, M.D. 25500 Point Lookout Road, Leonardtown, Maryland 20650 31. Date filed (Month, Par Year) 6 2005 32. 8 gistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#10e, perFH, 0856,6/21/06 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** 30, 2006 4c. County of Death Vernon Donald Green 12:00P May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hampstead

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 17327 Marshall Mill Rd. Carroll 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs. Director 217-16**-**6341 81 11/22/1924 MD Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits or then "naturel", or items 23a or 28a-f show the Medical Exempler must be notified at 1 ☐ Yes 2 X No Director MD Carroll Hampstead 10e. Steepend Number 10g. Citizen of What Country? 10f. Zip Code 17327Marshall Mill Rd. 21074 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1XX Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Btack, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White WWII 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement permit. Pages 1 and 2 should be filed to Department of Health and Mental Hyge. Important: If Item 27 is marked other 11 any njury or other traumatic event, Itte 2006. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို Raymond Green Lillian Snelling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17327 Marshall Mill Rd. Cleda Green Wife Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery 6/3/06 Hampstead, MD 22. Name and Address of Facility Eline Funeral Home e of Funeral Service Licenses 934 South Main_St. Hampstead, MD 21074 Yoland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4428 disease or condition resulting in death) COLON /Medical Due to (or as a consequence of): Examiner 11136768 MALLITUS TYPE Sequentially list conditions: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are conditions). Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed 40 that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 NO To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation м 1 ☐ Yes 2 ☐ No death. 2 Accident d in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10+1GrAF 1/06 9329 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tru 535 N. CIAZUSS ST PAGIM 2104 MES H 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

JUN 0 6 2006

06-03789 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Louis Allen Gross, III 2006 | 9562 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 3, 2006 0716 hrs Louis Allen Gross III Medical Examiner 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Port Republic 1960 Calvert Street Calvert 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or 5. Social Security Number **Funeral** Days Foreign Hours 217-45-7791 Director Country)Maryland 10 1 X M 2 1995 Yrs Sept.6 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits any 1 Yes 2 No or 28a-f show Maryland Calvert Port Republic or items 23a or 28a-f sho must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene aut. If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 1960 Calvert Street 20676 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes 1 Yes 2 No specify: Specify: black If Yes. Give Year 3 Widowed Divorced marked other than "natural", event, <u>the Medical Examiner</u> ģ 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (C-12) College (1-4 or 5+) Baltimore, MD 21215-0036 student student 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Allen Gross, II Mildred Dulaney Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is n r traumatic Mildred Dulaney- mother 1960 Calvert St. Port Republic MD 20676 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, Date Important: If ite 1 Burial 2 Cremation 3 Removal from State crematory or other place) Waters Memorial UM Cemetery St. Leonard Maryland Department Donation 5 Other Specify. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home 14405 Broomes Ts. Rd. Port Republic 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, seek, or lean Approximate Interval. Physician Between Onset and failure. List only one cause on each line /Medical Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b Were autopsy findings available has been 24a. Was an prior to completion of cause of autopsy performed? death? page 1 🗸 Yes certificate ✓ Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be examiner? Other₄ Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 🗸 Other: Scene dire ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b Time of Injury 28c Injury at Work 28d Describe how injury occurred Certification: Subject struck by vehicle FOUND: Natural 5 Pending Yes 2 V No Jun 3, 2006 0710 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State determined 1960 Calvert Street, Port Republic, MD (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 4, 2006 O.C.M.E. erson who completed cause of death (Item 23a) 30. Name and address of

111 Penn Street, Baltimore, MD 21201

ORIGINAL

Deputy Chief Medical Examiner

State Registrar Jack Titus MD
31. Date filed (Month, I

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Charlotte C. Grie					and Mental I	Hygiene	0.07		
_	F	- For State Registrar	Certific	cate of Death			g. No. 200	6 1956	
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Funeral		5. Social Security Number 6. Sex 7. Ag	e (în yrs. last bi			_	h(MM/DD/YYYY) 9. Bir Foreig		
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Henry Grierson/Husband		2320 Carte	er Avenue.	Dunkirk	MD 20754	1	
e, land Healt Healt item	ı	20a Method of Disposition		e of Disposition (Name o		Date	20c. Location - City or		
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Baltimore, permit Pages I a Department of He Important: If ite	ŀ	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	cnes	apeake Crer 22. Name and Add	to a second C T and City		Beltsville, MD		
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Sox leath for u	Sic	1 Yes 2 No 9 Unknown 9 Unknown		5 Other (Specify)					
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated	mination and/or	r investigation, in my op	inion, death occurred	at the time, date a	and place, and due to th	e cause(s)	
⊢ ≯ ⊢ 3	ž	29b. Signature and title of certifier		29c. Li	cense number		29d. Date signed (Moi	nth, Day Year)	
		106.11100AC.		0	.C.M.E.		June 5, 2006		
	-	30. Name and address of person who completed cause of	death (Item 23a)					
14		Zabiullah Ali, M.D. Assistant Medical E		111 Penn Street, I	Baltimore, MD 2	1201			
	ate		ar's Signature	Sparker					
Regist	trar	31 Date filed (Month Day Year) 32. Redistra	war B						

State of Maryland / Department of Health and Mental Hygiene - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUNE 3 **Physician** 2006 4:20 A. M Saundra Jane <u>Green</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Leonardtown

| Hunder 1 Year | Hunder 24 Hrs. | S. Date of Birth (Month, Day, Year) | Apr. 12, 1940 Mary's St. Mary's Hospital Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2\ F Yrs. Virginia Director 66 225-60-1307 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir then "naturel", or Iteme 23a or 28a-f ehow the Medical Exerctives must be notified at 1 ☐ Yes 2 No Director Lexington Park St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 46823 Bryan Road 20653 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced white Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fit f Health and Mental H item 27 is marked oth Cornelia Frazier Smoot Donald Treffield Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
important: if item 27 ie
eny injury or other trau 46823 Bryan Road, Lexington Park, MD 20653 Mark W. Green, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Mem. Gardens 06-06-2006 Leonardtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequençe of): Obstructive Pulmonay Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atter should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Muta stasis. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2∏ No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pendina 1 Natural 2 Accident 1 Yes 2 No death. investigation neral Director: A filled in by the fu 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitei or At within 24 hours after a To the Funeral Direct 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60888 0.6 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) R. KL Lo...
31. Date filed (Month, Day Year) M.D., 24035 Tree Notch Rd., Hollywood, MD 20636 32. Registras signature State E SUUE Registrar

Please Type or Print in Black Indelible Ink Richard W. George, III State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** Richard W. George, III 2219 hrs June 8, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Fort Washington Prince George's 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Days Hours Foreign N**iew** York Director July 14,199 1 XM 2 F 055-80-8151 14 Yrs Usual Residence of Decedent 10c. City, Town or Location any 10d. Inside City Limits or items 23a or 28a-f show 1 Yes 2 X No Indian Head Charles Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: filem 27 is marked other than "natural", or items 23a or 28a-f sho or other trannatic event, the Medical Examiner must be notified at once. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 20640 U.S.A. 6670 Indian Head Hwy. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funera 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 Never Married 2 Married White, etc. Armed Forces? Yes 2 **X** No 1 Yes 2 No specify: 3 Widowed If Yes, Give Year White Specify 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Scott Richard Lisa George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20640 19a. Informant's Name/Relationship (Type, Print) 6670 Indian Head Hwy., Indian Head, Lisa A. Liddle Mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) June 2006 1 X Burial 2 Cremation 3 permit Pages
Department or
Important: I Nanjemoy Baptist Church Nanjemoy, Maryland Donation 5 Other Specify 21 Signature of Funeral Service Licen 22. Name and Address of Facility Williams Funeral Home, P.A. 20640 M00668 4270 Hawthorne мã ease, or complications that eaused the death. Do not enter **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Hanging Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that Due to (or as a consequence of) events resulting in death) Last and transit sician/Medical attending physician a X UNPENDED AMENDED item#23a,27,28a-f,permE,G857,7/12/06 TT The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown Phv Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed as been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 1 🗸 Yes Νo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Yea 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 5 Pending Yes 2 χ No 6/8/2006 lınk the unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State 6670 Indian Head Hwy. Indian Head, MD determined Home (Specify) 4 Homicide 29a. Certifier 1 Medical (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 9, 2006 102 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar 31. Date filed (Month, Day, Year)

sistrar's Signatur

			1- For Amend Item 24a per verb., G856	artment of Health and M Chilicate of Death	lental Hyg	giene 2 () ()	6 19566						
			Decedent's Name (First, Middle, Last)		2. Date of Dea	ith	3. Time of Death						
	Physici: /Medic		Dorothy Rosemary Greenway		Month June	12, 2006 Ye	7:40 A ^M						
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of D							
			1505 Ladd Street	Silver Spring		Montgom							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 408-24-9171 93 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day August	Year) 9.	Birthplace (State or Foreign Country) ennessee						
Ь.	Director	-	Usual Residence of Decedent		Mugust	7,1712 1	Cilicagee						
	yland		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits						
	the Marylan 28a-f show notified at	ctor	MD Montgomery Silver	Spring			1 Tes 2 ANo						
	or 28	Dire	10e. Street and Number	10f. Zip Code		10g. Citizen of What	t Country?						
	s 23a	Funeral Director	1505 Ladd Street	20902	'/- \/ N -	U.S.A.	l dans la dina						
	Items Insert	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto	ecify Yes of No- Rican, etc.)	Black, W	American Indian, Vhite, etc.						
336	urs af	by F	If Yes, Give 3 💢 Widowed 4 🗆 Divorced Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify:	White						
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show ileal Examinat must be netitied at		15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work.	ino	16b. Kind of Busine	ess/Industry						
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Maryland	t be find He of others	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		мацеп Битате)							
Ž	should nd Me mark matic	2				r, City or Town, Stat	te, Zip Code)						
	nd 2 sulth ar 27 is r trau			-		•							
re,	ges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ir.a Medical Examinat must be natified at		cometeny cre	osition (Name of matory or other place)	Date	20c. Location - City	or Town, State						
Ĕ	Page nent c int: if iry or		1 A Burial 2 Gremation 3 Gremoval from State		2006	Bristol,	TN						
Baltimore,	permit. Pages Department of Important: If i any injury or one		Cynthia Garnette 1505 Ladd Street, Silver Spring, MD 2090 Method of Disposition 1XXeurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Shelby Hill Cemetery 6/16/2006 Signature of Fundal Service Licensee 220. Name and Address of Facility Mountcastle Funeral 1 4143 Dale Blvd., Dale City, VA 2219										
_	20529		Collo										
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arr	est.	Approximate Interval Between Onset and Death						
	Physician		Immediate Cause (Final disease or condition resulting in death)	thre pulmonary	diseo	se	years						
	/Medical Examiner		Due to (or as a consequence of):				1						
		er	Sequentially list conditions, b. Due to (or as a consequence of):										
	d d ansit	Examin	ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
ó	be executed ician and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):										
8760,	cate be ex chysician the buria	dlcal	d										
9	eath certificate attending phys for use as the	Ø.	IF FEMALE: 23a If you guitage of programmy										
Вох	atter for u	lan	In the past 12 months:	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year						
Ö	9 m D	Physician/M	1 Yes 2 No 9 Unknown	J Other (Specify)									
σ.	requires that the een signed by th nould be detache		Part II. Other significent conditions contributing to death but not resulting in the	nderlying cause given in Part I.	23e. Did to	bacco use contribute	e to the cause of death?						
rds	w requires that s been signed t should be deta	ed b	congestive heart failure		150	es 2□No 3□	Probably 4 Unknown						
900	aw as b	Completed by	renal insufficiency		24a. Was a	24b. Were	autopsy findings available to completion of cause of						
- B	The ate h	Som	3		perfor	med? death	1?						
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	(Check only or									
of Vital Records,	hys this	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie				Specify)						
uc	ffer ffer inei	tlon	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. T	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	280. Describe III	ow injury occurred							
Division	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st				Rural Route Number,						
Ö	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Tow	n, State)							
	ospita hours unera ly fille	alc	29a. Certifier 12 Certifying Physicien: To the best of my knowledge, deal										
	he H in 24 he Fu	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or in one)										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	29c. License number		9d. Date signed (M							
•			1 Cuth 1 even - Collen	N 133159		June 10	, 2006.						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Dr. Ruth Kevess-Cohen 8700 Geo:	Print) rgia Ave., Suite 4	00. Silv	ver Spring	e. MD 20910						
	Sta	te.	31. Date filed (Month. Day, Year) 32. Registrar's Signature		OU, DII	. CI DP LIN	5, 110 20710						
	Registi		JUN 2 0 2006 June 15 April	JUN 2 0 2006									

ician	Decedent's Name (First, Middle,			** **		2. Date of Dea Month	Day	Year	3. Time of	Death
dica	MICHael	Nyrop		Hoffm		May	30	2006	1:00	р М
inei	4a. Fecility Name (If not institution, 1536 Manor Vie			, ,	r Location of Death			ounty of Death	. 1 1	
		Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	dsonville	8. Date of Birt		Anne Ar		or Foreig
	5. Secial Security Number 261-50-6722 Usual Residence of Decedent	1 X M 2□F 60	Yrs.	Months Days	Hours Min.	(Month, Day	r, Year)	46 Mary	place (State ontry) land	or rureig.
	10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside C	ity Limits
1	MD Anne A	rundel	Davids	onville					1 🗆 Yes	2 X N
Director	10e. Street and Number		_	10f. Zip Code			10g. Citize	n of What Cou	ntry?	
107	1536 Manor Viev	Road		L.	035			USA		
hy Firmarai		12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 No 1f Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	lispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		. Race - Americ Black, White, pecify: Wh		
7	15. Decedent's		16a. Dece	dent's Usual Occup	pation		16b. Kind	of Business/In	dustry	
Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Give	kind of work done DO NOT use retire	during most of work d)	ing			,	
and a	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Print	er/Publis	sher		Pub1	ishing		
BAC	17. Father's Name (First, Middle, L.	15t)			18. Mother's Name	e (First, Middle,	Maiden Su	ımame)		
5			-		Vesta E.	. Nyrop				
ľ	19a. Informant's Name/Relationshi	• • •	19b. Mailir	ng Address (Street	and Number or Rura	al Route Numbe	r, City or T	own, State, Zip	Code)	
	Michael R. Hoff				w Drive, (
	20a. Method of Disposition 1 ZBurial 2 ☐ Cremation	20b. F B □Removal from State	Place of Dispo cometery, crer	sition (Name of matory or other plac	ce)	Date	20c. Loca	tion - City or Te	own, State	
	4 □ Donation 5 □ Other (Spe	ocity) Ste		lle Cem.		-2006	Steve	ensvill	e, MD	
	21. Signature of Funeral Service L	censee	22	Name and Addre Hardesty	ss of Facility Funeral I	Home, P.	Α.			
	129-9-00			12 Kidge.	Ly Avenue	,_Annapo	lis,	MD 214		
	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a conseq					rest,		Approximat Interval Bet Onset and	tween
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a	Sequentially list conditions, in any, leading to immediate	b. HUBERTE	uence of):	·				-	541	
	cause. Enter Underlying Cause (Disease or injury								541	25
Evamin	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):							
100		CONGESTIV	ie He	TART F	The Lucies				541	ر -
-							-			
veirian/Mad	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ildeath 3□	Ectopic pregnancy Other (specify)	ý		230	d. Date of delive Month	•	Year
Dhyei	Part II. Other significant condition	s contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of d	death?
4	00-		_			1 DY	es 21/21	No 3 □ Prot	ably 4 ⊡t	Unknow
ata										
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B	examiner?	Hospital:		Oth	26. Place of Death					
۲		1 Inpatient 2 28a. Date of Injury	ER/Outpatien		er: 4 ☐ Nursing Ho	me 5 Hesid 28d. Describe h			y)	
1	1 Matural 5 Pending 2 Accident investiga	(Month, Day Year)	Injury	Wor	rk? Yes 2 □ No					
Cartification.	3 Suicide 6 Could no 4 Homicide determin	treet and f n, State)	Number or Rura	I Route Num	iber,					
Madioal		Physician: To the best of my know kaminer: On the basis of examina and manner stated.	owledge, death	n occurred at the tir vestigation, in my o	me, date and place, opinion, death occurr	and due to the deed at the time, o	ause(s) ar late and pl	nd manner as s ace, and due to	tated. o the cause(s	\$)
2	29b. Signature and title of certifier	Va		29c. Licens	se number			igned (Month,	Day, Year)	
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	I conside	Chtmark)		00	REEN C		0/0	2100		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tem 5 per 1h 9856 6-23-06 vt. State of Maryland / Department of Health and Mental Hygiene () () 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Penny Month Year Ann 545AM eintzelman 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Nursing Vaddock Heights
Under 1 Year If Under 24 Hrs 8. Date Home indobona Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Min. Days Hours Months 1 M 2000F Sep. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2XXNo Frederick Braddock Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6012 Jefferson Blvd. 21714 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 never worked n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles A. Heintzelman Marie Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean M. Bricker sister 10912 Hartle Drive Harerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XDBurial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Ouincy Cemeterv 06/19/2006 Orincy, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Ind 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. 50 S. Broad Street Waynesboro PA 17268 Approximate Interval Between Onset and Death Congestive disease or condition resulting in death) robuble Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2. 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

/Medical Examiner attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760. ed by the a ed bluods certificate has After or Attanding after death. filled in by To the Hospital within 24 hours a To the Funeral I cal

Physician/Medical þ Completed Be 2

Examiner Certification:

Physician

/Medical

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7 is marked other than "natural", or items 23a or 28a-f show traumatic avant, it e Madical Exspirer musi be notified at

2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Itel

permit. Pages 1 and 2 Department of Health a Important: ff Item 27 is any injury or othar tra QDCs.

Priysician

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 ☐ Yes 2 KNo

27. Manner of Death Natural 2 Accident 5 Pending investigation 3 Suicide

4 Homicide

29a. Certifier

6 Could not be

28a. Date of Injury (Month, Day Year)

28c. Injury at Work? М 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Brummye, MD Z1716

29b. Signature and title of certifier

~ua/Mos

determined

29d. Date signed (Month, Day, Year) 12006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

610 9th Ave , MID CHAN-HWGHO

31. Date liled (Month, Day, Year)

JUN 2 1 2005



DHMH 17 Rev 1/2001

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 9569 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **E**hysician James Kelly Harris June 2006 8:20a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harbor Hospital Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Hours 1**X** M 2□ F Yrs. 62 Director 419-54-3386 Nov. 28,1943 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b Counts 10d. Inside City Limits 28e-f ehov traumatic event, the Medical Examinar must be confilled at MD 1 ☐ Yes 2 No Directo Anne Arundel Severna Park 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ŏ 810 Manhattan Beach Road permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Insportant: if Item 27 is marked other than "naturar, or liems 23a any njury or other traumatic event, tra Nuclea 21146 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 **∑**Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer Filtration Company 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kelley Vann Harris Virgie Salema Rhea 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Harris/Wife 810 Manhattan Beach Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 6, 1

Burial 2 □ Cremation 3 □ Removal from State Hillcrest Cemetery Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Puneral Service, Licer Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** ardio DWI disease or condition resulting in death) monary minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 0 No 2 🗌 No 1 ☐ Yes : After this certification : Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pendina 1 ☐ Yes 2 XNo investigation 820AM after death. une 2 2006 Director: / the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide land Lai Mary Battimore within 24 hours a To the Funerel I completely filled i the Hospitei Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 0055662 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) South Hanover Street astellone 3001 31. Date filed (Month, Day, Year) 32. gistrar's Signatur State JUN 0 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear ERRMANA Month **Physician** DWARD 2243 200% /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 10 M 2 ☐ F **Funeral** Months 87 Yrs Mar 10, Maryland Director 216-09-4905 Usual Residence of Dece 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 28a-f ahow the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Itema 23a or 105 Round Bay Road 21146 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced natural WW II Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Engineer 5+ Pages 1 and 2 should be filed w timent of Health and Mental Hygien tant: If item 27 is marked other ti jury or other traumatic event, ID. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edward Herrmann Elizabeth M. Easter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD 21146 Capitola Herrmann/Wife 105 Round Bay Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NULUMONIA DIRATION Physician /Medical Due to (fr as a consequence of): Examiner ZHEIMERS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of) Box 68760. by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 100 1 TYes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Magner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifie who completed cause of death (Item 23a) (Type, Print)

A FENDA M 441 DEFENSE HIGHWAY ANNAPOUR MOZIYOL

State Registrar 31. Date filed (Month, Day, Year)

JUN 0



		1	For State Registrar	State of M	Maryland		artment of I		ind M		giene Reg. No.	06	19571				
	Physicia		1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Year	3. Time of Death				
	/Medica	al -	Charles B.	House, J				. 1	(5)	June		2006	1:20 p. ^M				
	Examine	er	ta. Facility Name (If not institution, The Chateau of		*****		4b. City, Town, o	erland			4c. Cou	nty of Death					
E	uneral			6. Sex 7	Age (In yrs. la		If Under 1 Year	If Under 2	24 Hrs.	8. Date of Bir	th	Alleg g. Birth	pplace (State or Foreign untry)				
	irector		214-07-4184	1 X M 2□ F	88	Yrs.	Months Days	Hours	Min.	(Month, Da June 1	y, Year) 6,1917		ersdale, PA				
and	*	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits				
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h the	r 28e	Director	10e. Street and Number	laı		reyser	10f. Zip Code				10g. Citizen	of What Cou	untry?				
E wi	23a o		Rt. 3, Box 32	241 Linder	n Drive	e	267	26				USA					
эг дөа	tems ar I.u	Funerai	11. Marital Status	12. Was Decede Armed Force 1 X Yes 2[nt Ever in U.S	S. 13.	Was Decedent of I	lispanic Orig	in? (Spe	ecify Yes or No Rican, etc.)	- 14. F	lace - Amer					
36 rs afte	, or i	by F	1 ☐ Never Married 2 ☐ Marrie 3 🕱 Widowed 4 ☐ Divorced	In Market 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		_	1☐ Yes 2XNo	Specify:			Spe		1				
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21 Jygien	it.		12			Bob	bin Stor						anufacturing				
aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene.	ed of	m	17. Father's Name (First, Middle, L	,						(First, Middle,		ame)					
should Me	mark	၉ .	Charles B. Ho			19b. Maili	ing Address (Street		-	Burkh:		vn. State. Z	ip Code)				
Nd 2:	27 is		Doris D. Pitr		er		l Poplar				-	2650	_				
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours at partment of Health and Mental Hygiene.	item othe	Ì	20a. Method of Disposition			ace of Dispo	osition (Name of	1	- 0	ate	20c. Location - City or Town, State						
imo Page Tient	ant: If ury o																
Balt permit. Depart	Important: If Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Mudical Execution that Le notified at once.																
4			23a. Part1. Enter the disease, or c shock, or heart failure. List of	nly one cause on each	n line.		ter the mode of dyi	ng, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death				
	sician		Immediate Cause (Final disease or condition resulting in death)	-a. acm	te MI					minute							
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,60°,	physicism and the burial-transit	Icai Ex	resulting in death) Last	Due to (or	as a consequ	uence of):											
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of Vital Records, P.O. Box 60 Physicien: The law requires that the death certific	ettending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregna		⊒Ectopic pregnanc	v				Date of deliv					
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P.C				s contributing to deat	h hut not resu	ultion in the u	inderlying cause or	ven in Part I		23e Did t	nhacco use co	natribute to	the cause of death?				
ds,	s been signed be should be det	d by											babiy 4 Unknown				
COL	shou	iete	9 Schaeime Candir mu Duti									b. Were aut	topsy findings available				
Re la	2º CI	Completed by	300000000000000000000000000000000000000	wie roge pe	nig .					autor	nsy med?	prior to co death?	ompletion of cause of				
ital en:	rtifica stor, p	0	25. Was case referred to medical		,			26. Place	of Death	1 Yes	ne)	1 🗌 Yes	2 No				
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isic Isic Itiend Geath	ctor:	licat	2 Accident investig 3 Suicide 6 Could n	ot be	Injury - At ho	me farm st	M 1 [Yes 2 N		28f. Location /	Street and Nu	mber or Ru	ral Route Number,				
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To the within	To th comp	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D									, Day, Year)						
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	b	- 1	30. Name and address of person v		-	, , ,,	Print)										
	Sta	10	Huma Shakil, 31. Date filed (Month, Day, Year)		Kent istrar's Signal		e Cumbo	erland	, MD	2150	12						
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DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2 0 0 6										19572	
by Funeral Director			Decedent's Name (First, Middle, Last)						2. Date of Deat Month	th Day	Year	3. Time of Death		
			Dora Isabel Hersey							June 13	ne 13, 2006 11:20 AM			
			4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Dea				
			19223 Middletown Rd.				Parkton				Baltimore			
0	Funeral		5. Social Security Number 6. Se	x 7 □M 2 ⊠ F	. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Jan. 21	Year)	Cour	place (State or Foreign	
ica	Director		Usual Residence of Decedent	<u> </u>	94	Yrs.				Jan. 21,	, 1912	Mar	ýland	
	and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits	
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\approx	28a	rect	10e. Street and Number 10f. Zip Code							1	Oa. Citizen of	Dg. Citizen of What Country?		
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20	death with the Maryland oms 23s or 28s-f show ir must be notified at	Funeral Director	11. Marital Status	lent Ever in U.	ver in U.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto				ecify Yes or No-			- American Indian,		
, o	after or its	Ē	1 X Never Married 2 ☐ Married	Armed Ford 1 Tes 2 If Yes, Give	X No					Hican, etc.)		ck, White,		
3 6	A 1A 100000 of within 72 hours after death with the Marylan glene. er then "natural", or Items 23e or 28e-f show in the Medical Examinar must be notified at	l by	3 ☐ Widowed 4 ☐ Divorced	es:	1 ☐ Yes 2X No Specify:				Specify: White			ite		
5 P		Completed by	15. Decedent's Education 16a (Specify only highest grade completed)				Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
Z 2		mpi	Elementary/Secondary (0-12) College (1-4or 5+)								Clothing Mfg.			
DD AG nd 21215-	D D F	ပိ	12 17. Father's Name (First, Middle, Last)			Sea	nstress	10 Math	or's Nome				rg.	
V i De	uld be fill fental Hy rked oth	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumai Barbara E. Winemi											
ary in	" = = =		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									Code)		
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S. S.	of He of He item		20a. Method of Disposition	2	20b. P	lace of Dispo	sition (Name of natory or other pla	ce)			20c. Location	City or To	wn, State	
Heres Baltimore	Pages nent of I ent: if it		1 Burial 2 Cremation 3 □I 4 Donation 5 □ Other (Specify,		Pir Met	e Gro hodist	sition (Name of hatory or other pla Ve United Cemetery	7	2006	17,	Parkto	on, I	MD	
Je salt	permit. Depertre Importe any inju		21. Signature of Funeral Service Licens	90/	J	22	. Name and Addre	ss of Facili	ity J.	J. Hart	ensteir	Mort	uary, Inc.	
T -			21. Signature of Funeral Source Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24. Second St., New Freedom, PA 17349											
			23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between										Interval Between	
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ita	iician: Th certificete rector, peg	Bec	25. Was case referred to medical examiner? 26. Place of Death (Check only one)											
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Ξ	or At offer of Direct in by	Certification:	4 Homicide determined	286. Place o	f Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, stre v)	eet, factory, office		1	28f. Location (Sti City or Town	reet and Numb ı, State)	er or Rura	l Route Number,	
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		Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the To the Comp	Σ	29b. Signature and title of certifier	10			29c. Licens	se number		25	9d. Date signe	d (Month, L	Day, Year)	
			10/1 thathun	Kuli	, un	0	12	51	05		Jone	14,	2006	
_	5		30. Name and address of person who c	ompleted cau	of death (Item	23a) (Type,	D2 Print) Charl	. ()	2	Of mi	2.			
	`		W. V4-11. (Ry	(5BM)	6/		· Charl	6JF.	1700	eloi Ma	- C (5 () <u> </u>		
State Registrar 31. Date filed (Month, Day, Year) 32. Projector's Signature														

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 11 6

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		_	For State Registrar		arylana / l		tificate of L			Reg. No.		! 5370	
	Physici /Medic	an	Decedent's Name (First, Middle, Last John Albert						June 9	Day Day	1006 Year	3. Time of Death 9:00 p M	
	Examir		4a. Facility Name (If not institution, given 744 Old Baltimore	_)		4b. City, Town, or Westmi	Location of Death		4c.	County of Death Carroll		
3. 3-1	Funeral Director		5. Social Security Number 6. S		ge (In yrs. last bii 62	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jun 20	th ay, Year) 194	9. Birth Cou Mary	place (State or Foreign ntry) Land	
	Maryland f ehow	tor	Usuat Residence of Decedent 10a. State 10b. County Maryland Carrol	<u> </u>	10c. City, Tow	vn or Loc		estminste	er			10d. Inside City Limits	
	h with the	Funeral Director	10e. Street and Number 744 Old Baltimore	Road			10f. Zip Code	21157			zen of What Cou	ntry?	
036	is 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f ehow other traumatic event, the Medical Exactinat must be notified at	Ď	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 35 If Yes, Give Year or Dates	?	-	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specity:	pecify Yes or No Rican, etc.)		14. Race - Ameri Black, White, Specify: W		
21215-0036	within 72 ho jene. r than "natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 10	ducation ide completed) College (1-4or		(Give :	ent's Usual Occupa kind of work done of OO NOT use retired penter	during most of worl	king		Construction		
Maryland 2	uld be filed fental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last, Albert John Hyr					18. Mother's Nam Mildred	ne (First, Middle d France				
	and 2 should alth and Men 27 is marke		19a. Informant's Name/Relationship (Leona M. Hymille				-			-	ity or Town, State, Zip Code) nster, MD 21157		
Baltimore,	Peges 1 en nent of Heal int: If Item 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				sition (Name of natory or other place canch Cem	. 06/14	Date 4/2006	West	cation - City or T minster	, MD	
Balti	permit. Peges 1 Department of H Important: If Ite ony Injury or ot		21. Signature of Funeral Service Lice	OM BASE	1191		Name and Addres					ral Home 157	
	Physician /Medical		23a. Part). Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	ed the death. Do line.	fe	er the mode of dyin	g, such as cardiac	Λ	errest,		Approximate Interval Between Onset and Death	
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.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		e of pregnancy 2 Fetal death at time of death	eath 3 Ectopic pregnancy					23d. Date of delivery Month Day Y		
S, D	sign and b	by	Part II. Other significant conditions	contributing to death	but not resulting	in the u	nderlying cause giv	en in Part I.	1		7	the cause of death?	
Record	: The law requicete has been page 2 should	Completed									24b. Were aut prior to co death?	topsy findings available ompletion of cause of	
Vital	Physiclan: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			oth Oth	26. Place of Dea	ath (Check only				
ō	ng Phys Ater this Ineral dii	tion: To	1 Yes 2 No 27. Manner of Peath 1 Datural 5 Pending 2 Accident investigation	28a. Date of In (Month, L		Outpatien Time of Injury	28c. Injur	4 Nursing n	ome 5 Res 28d. Describe		6 Other (Spec y occurred	rfy)	
Division	r Attenter deel	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined		njury - At home, (etc. (Specify)	farm, str	eet, factory, office			(Street and		ral Route Number,	
	To the Hospitel or Attenwithin 24 hours after dealt To the Euneral Director: completely filled in by the	Medical C		hysician: To the bearings: On the basis and manner	of examination a								
	in	Me	29b. Signature and une of certifier	ela	MD		29c. Licens	054 2	218	29d. Dat	te signed (Month	, Day, Year) - 06	
	M3		30.1 Teme and address of person who Ramar	F 1 1 2	death (Item 23a	34°	Print) Male	nu cli	eve, h	011-	mitte	-06 MD 21137	
*	St	ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature								

DHMH 17 Rev 1/2001

State

Registrar

JUN 1 2 2006

ORIGINAL

Slave & Speck

	•	For State Registrar	State of Maryla		artment of rtificate o			iene g. No. 4	2006	19574
* 4.	de Tage	Decedent's Name (First, Middle, Las.	1)				2. Date of Deat	h		3. Time of Death
Physicia /Medic		WILLIAM	G	HUPF	ELDT		JUNE	Day	Jw6 Jw6	6:45 AM
Examine		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Deat	h	4c. C	County of Death	
	2	5. Social Security Number 6. Se	R NECK R	こ <mark>イ</mark> り . last birthday		STERTUS			KENT	lana (State or English
Funeral Director		216 20 6074	XM 2□ F 80	Yrs.	Months Day		(Month, Day,	Year)	Coun	lace (State or Foreign try)
yland	1	10a. State 10b. County		ity, Town or L					1	0d. Inside City Limits
ith the Marylar or 28a-f show	ctor	MD KEN	JT.	CHES	TERTO	WN				1 Yes 2 No
or 28	Dire	10e. Street and Number			10f. Zip Code	1620	1	0g. Citize	en of What Cour	,
ter death w Items 23s rer must	erai		12. Was Decedent Ever in U				` V N-	1.0	U.S.A.	
10 0 0	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:	_	of Yes, specify Cu 1 ☐ Yes 2 N	f Hispanic Origin? (Suban, Mexican, Puer o Specify:	to Rican, etc.)		Black, White,	etc.
72 hours natural', dical Exe	ted t	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occ	upation		16b. Kind	d of Business/Inc	dustry
thin 72	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of work don DO NOT use reti	ie during most of wo red)	rking		_	
1 and 2 should be filed within the Health and Mental Hygiene. Items 27 is marked other than other traumatic event, the Mental Hygiene.	Con	12	4	1	NEAT P					DUSTRY
tally land to the tied wand Mental Hygie is marked other tieumatic event, the	Be	17. Father's Name (First, Middle, Last)		41	_		me (First, Middle, M		ŕ	
should nd Men r marke umatic	ှ	19a. Informant's Name/Relationship (T	LISTOCHER		FELDT	et and Number or B			LUDER	BERG Code) 21620
and 2 s ealth an n 27 is i		MARGARET K. HU		790		KER NEC				
es 1 and of Health fitam 27	117	20a. Method of Disposition	20b.		osition (Name of matory or other p	lace)			ation - City or To	
Pages Hent of I int: If it		1 ☐ Burial 2	Removal from State	LESTER	CREM	ATOR) 6/	3/06	Cite	STEL	MD.
permit. Page Department Important: I eny injury o		21. Signature of Funeral Service Licens								DIRECTUR
80 6 8 9		Marin V. a	alling)		205 61	seen He	exial wa	4 (371315	ETUINA MO
# \$ J		23a. Part1. Frier the disease, or comp shock, or heart failure. List only of	lications that caused the dea	ith. Do not en	ter the mode of d	ying, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
Physician	Ì	Immediate Cause (Final disease or condition resulting in death)	a VENNICU	CAR 1	Decryca	RDIA				Criset and Death
/Medical Examiner			Due to (or as a conse	quence of):						
**	e	Sequentially list conditions, if any, leading to immediate	b. Due to for as a conse	quence of).						
uted	Examin	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
be executed sician and burial-transit		resulting in death) Last	Due to (or as a conse	quence of):						
ate be exhysician	lical		d							
se as	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregr	ancy.						
attend for us	cian	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of	al death 3	Ectopic pregnan Other (specify)	псу		23	d. Date of delive Month	ny Day Year
y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	304	_ Gillor (Speelify)					
w requires that the death certificate been signed by the attending phenould be detached for use as t	by Pi	Part II. Other significant conditions co		sulting in the u	inderlying cause o	given in Part I.	23e. Did tob	acco usi	a coptribute to th	e cause of death?
equire en sig		1400 ISCHUN	VIC CASOIL	mya	rany		1 ☐ Ye	s 2	No 3□Prob	ably 4 Unknown
law re as be	ompleted	·			1		24a. Was ar autops			osy findings available inpletion of cause of
ding Physician: The lav h. After this certificate has funeral director, page 2	Com						perform	1ed?	death?	2 No
ician: ertific ector,	Be	25. Was case referred to medical examiner?	Unanital:		16		ath (Check only one	9)		
Physi this o	2	1 Yes 2 No 27. Manner of Death		ER/Outpatie	IL SUDON	ther: 4 Nursing F			Other (Specify)
ding I	tion	1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury	W	ork? ☐ Yes 2 ☐ No	28d. Describe ho	w injury	occurrea	
Atten deat ctor: by the	fica	3 Suicide 6 Could not be	286. Place of injury - At I	nome, farm, st			28f. Location (Str	eet and	Number or Rura	l Route Number,
al or safter	Certification:	4 Homicide	building, etc. (Spec	ify)			City or Town	, State)		
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 54 hours after death. To the Funerial infector: Attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medicai (29a. Certifying Phy (Check only one)	vsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the evestigation, in my	time, date and place opinion, death occu	e, and due to the caurred at the time, da	use(s) a ite and p	nd manner as sta lace, and due to	ated. the cause(s)
To th Within To th comp	Me	29b. Signature and title of certifier	nf/		29c. Lice	nse number	29	d. Date	signed (Month, L	Day, Year)
		> //Wohul	14		$-\mid \mathcal{D}$	00603	301	6	12/06	!
) I grates	1	30. Name and address of person who a		26a) (Type	Print) O	N co-	CHEST	0.4	A	4.0
me		MICHALOC A-	MON WD	000 5	OOK P	V 7183	ردحاب	ove	our,	141)
Sta Registra		31. Date filed (Month, Day, Year)	32. Regulfrar's Sign	lature A	E. H.					

ORIGINAL

			1 - For State of M	/larylanc	d / Departr	ment of He	ealth and N	-	iene 2006.	10575
			Registrar 1. Decedent's Name (First, Middle, Last)		Certiti	cate of D	eath	2. Date of Deat	eg. No.	3. Time of Death
	Physicia		Walter Jay	Hall				Month	Day. Year	10 11:15 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number		4b	City, Town, or	Location of Death	Julio	4c. County of Dea	th
			Citizens Nursing	Hon	ne r	avre	De CIK	race	Harto	RO
	Funeral Director		5. Social Security Number 6. Sex 213-28-1663 1√2 M 2□ F	Age <i>(In yrs. l</i> a 75		Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day, June 16	Year) 9. Bin C.	thplace (State or Foreign ountry) ennsylvania
			Usual Residence of Decedent						, 2000	
	farylar show	ğ	10a. State 10b. County Maryland Ral+imoro	10c. City,	Town or Location					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the N 28a-f	Director	Maryland Baltimore 10e. Street and Number		1	Baltin Of Zip Code	nore	1	0g. Citizen of What C	
	th with		10 North Calvert Street,	Suite			21202		U.S	•
	tems :	Funeral	11. Marital Status 12. Was Deceden Armed Forces	nt Ever in U.S		Decedent of His s, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	irs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ If Yes, Give Year or Dates]No ::1951-!	10	Yes 2⊠ No	Specify:	.:	Specific	√ Vhite
21215-0036	be filed within 72 hours after death with the Marylan lal Hygiene. Ind other than "naturel", or Items 23a or 28a-1 show event, It e Medical Ever, it at must be to diffed at		15. Decedent's Education (Specify only highest grade completed)		16a. Decedent	s Usual Occupa	tion uring most of work	ina	16b. Kind of Business	
121	within ne.	Completed	Elementary/Secondary (0-12) College (1-40)	r 5+)	life. DO N	IOT use retired)		,,,,		
	filed v Hygie other t	ဝင္	unknown unknown 17. Father's Name (First, Middle, Last)		Ch	erry Fa	rmer 18. Mother's Nam	e (First, Middle, M	Agricul	ture
<u>la</u> n	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28a-f show eumatic event, If a Medical Exartinating the rediffied at	ToB	Lee Hammond Hall				A	da Zellm	an	
Maryland	d 2 should th and Men 7 is marke treumatic	·	19a. Informant's Name/Relationship (Type, Print)						City or Town, State,	
	an leal m 2		Mark Carroll (Guardian) 20a. Method of Disposition				ory, Bel		ryland 21 20c. Location - City or	O14
JÕE L	Pages nent of t ont: if its		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	.6	ace of Disposition metery, cremator ison Fores				wings Mills,	
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Licensee		22. Na	me and Address	of Facility			-
<u> </u>	89EE9		Thomas M. Talle	MAGE	Perr	yville,	Marylan	d 21903	eral Home, 3-0766	P.A.
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. line.	Do not enter th	e mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	um is a conseque	nna off:					5 days
	Examiner				51100 517.					9
RI	be sit	iner	cause. Enter Underlying	is a conseque	ence of):					
	axecut	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	is a conseque	ence of):					
8760	ysicial	icai	d							
9	ertifica ting ph	Med	IF FEMALE:							
Box	eath c attend	Physician/Med	23b. Was decedent pregnant in the past 12 months?	2 Fetal o	death 3 □Ecto	opic pregnancy er (specify)			23d. Date of de Month	livery Day Year
P.O.	it the d by the tachec	hysi	1 Yes 2 No 9 Unknown 9 Unknown							
91	res tha	by	Part II. Other significant conditions contributing to death	but not result	ting in the underl	ying cause giver	n in Part I.		acco use contribute to	
MIt	v requi	Completed	Cht & call	Re	10	Denle	7 - 0	1 ☐ Ye	7	obably 4 Unknown
Re	he lav e has age 2	dwc	Description of the state of the	1	my	Bush		24a. Was ar autopsy perform	y prior to ned? death?	utopsy findings available completion of cause of
ital	ien:]	BeC	25. Was case referred to medical	13			26. Place of Deatl	1 ☐ Yes 2		2□ No
) Stv	hysic this ce al dire	은			R/Outpatient 3	□ DOA Other	4 Nursing Ho		nce 6 Other (Spe	cify)
7000	ding F h. After funera	tion:	27. Manner of Death Natural 5 Pending Natural investigation 28a. Date of Investigation	ay Year)	28b. Time of Injury	28c. Injury	es 2 No	28d. Describe ho	w injury occurred	
$\mathcal{H}_{Division}$	Atten er deal ector: by the	Certification:	3 Suicide 6 Could not be 28e. Place of Ir	njury - At hometc. (Specify)	ne, farm, street, f			28f. Location (Str	reet and Number or Ru	ural Route Number,
Di	itel or ars afte ral Dir	Cert	50.0					City or Town		
	Hosp 24 hou Fune stely fi	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the bess 2 Medical Examiner: On the basis and manners	of examination	riedge, death occ on and/or investig	urred at the time gation, in my opi	e, date and place, nion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
_	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	29b. Signature and title) of certifier			29c. License	number	29	d. Date signed (Mont	h, Day, Year)
			Whelen no	'		D-15	994		6-2-06	
_			30. Name and address of person who completed cause of			*				
	VA Sta	te.	Leticia S. Galvez, M.D., 6 31. Date filed (Month, Day, Year) 32. Regis				e, Havre	de Grace	e, Marylan	d 21078
	Registr		31. Date filed (Month, Day, Year) 32. Regis	, J.	good	,				

			1 - State Registra Amend Item #2	State of Mary					giene 2 🛭 [Reg. No.	16 19576
	Dhusisi		Decedent's Name (First, Middle, Last)	o Per FH (30.70 0/20	/UO JH		2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Margaret Tucker	Harvell				June	2, 2006	
0	Examin	er	4a. Facility Name (If not institution, give st 2020 Brooks Drive,			Forestv:	Location of Death ille, Ma:	ryland	4c. County of C	
	Funeral Director		5. Social Security Number 6. Sex 229-34-4914A		n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt		Birthplace (State or Foreign County) TIPSINIA INCE GEORGECTY
	and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation	-			10d. Inside City Limits
	Maryl	to	Virginia Prince Ge	orge D	inwiddie,	Virginia	a			1 Yes 2 □ No
	or 28s	Director	10e. Street and Number	-		10f. Zip Code			10g. Citizen of Wha	
	s 23a	rai	21703 Carson Road	. W D		23841	0::0:		United St	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Itsm 27 is marked other then "natural; or Items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 Tyes 2 Ano If Yes, Give Year or Dates:	1	was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 → No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	city Yes of No- Rican, etc.)	Black, V	American Indian, White, etc. Llack
15-0	"natu	letec	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	tent's Usual Occupa kind of work done of DO NOT use retired	furing most of workit	ng	16b. Kind of Busine	ess/Industry
212	within iene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		istrator)		Tobacco	/ Private
pu	should be filed within and Mental Hygiene. Is marked other then aumatic event, the Ms	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sumame)	
Maryland	should be ind Mental in marked or	To	Robert Tucker		1			Unk.		
Mar	d 2 sh th and th and 7 is m traum		19a. Informant's Name/Relationship (Typ						er, City or Town, Sta	V 2000
ē,	ges 1 and 2 if of Heelth if Itsm 27 i		Vera Dinette Harve 20a. Method of Disposition	1	20b. Place of Dispo		D	ate	20c. Location - City	Maryland 20747 yor Town, State
E OE			1√ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		*		"Pk. 6/1	0/06	Dinwidd	ie. VA
Baltimore,	permit. Page Depertment of Importent: if any Injury or ance.		21. Signatura Fun ral Service Licens		22 1	ope Fune	rafacilyones	, P.A.	tville, M	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resistance, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate									Approximate Interval Between Onset and Death a Se
68760,	ficate be executed physician and is the burial-transit	edical Examin	that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):					
O. Box	the death certi by the ettending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
rds, P.	w requires that s been signed b should be deta	þ	Part II. Other significant conditions conf	ributing to death but n	ot resulting in the ur	nderlying cause give	en in Part f.			te to the cause of death? Probably 4. Tonknown
I Records,	w	Completed						24a. Was a autop perfor 1 ☐ Yes	rmed? _ prior deat	
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:		Othe	26. Place of Death			Daughter,s
Division of	ng Phys fter this ineral di	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye		28c. Injury Work	4 □ Nursing Hon vat (? Yes 2 □ No	8d. Describe h	ow injury occurred	Residence
Divi	Ital or At		4 Homicide determined	28e. Place of Injury building, etc. (S	· At home, farm, str Specify)	eet, factory, office	2	8f. Location (S City or Tow		r Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical	(Check only 2 Medical Examin	cian: To the best of m er: On the basis of exa and manner stated	amination and/or inv	estigation, in my or	pinion, death occurre	d at the time, o	date and place, and	due to the cause(s)
	To To Con	Σ	29b. Signature and title of certifier	10 0	_ D = 1	29c. License	number	= 17	29d. Date signed (M	2001
2	(b)		30. Name and address of person who cor	ted cause of death	n (Item 23a) (Type,	Print)	7055	16	one of	es lossed
1	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's	Signature _	ma	er i roc		7)	rigiona
	Regist		JUN 0 6 2006	Medie .	& Good	L.				

		Flease			ortmost of Hoolth and		•	
		1 _ State	State of Mar		artment of Health and	Mental Hygie	ene 2 0 0 6	19577
		Registrar		Ce	rtificate of Death		. No	1 2 0 1 1
Physic	ian	1. Decedent's Name (First, Middle, La		Tal	,	2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal		monis	Johns		100	31 2000	
Exami	ner	4a. Facility Name (If not institution, giv	- 11 1 04	Engtain	4b. City, Town, or Location of Deat	n	4c. County of Dea	th +
		Memorial Ho:	>pital at	MS VIII	Easton If Under 1 Year If Under 24 Hrs	O Date of Birth	1915	the land (State on Fauring
Funeral		5. Social Security Number 6. S	M 2 2 F 7. Age (In yrs. last birthday Yrs.	Months Days Hours Min. 1 15	(Month, Day, Y	ear) 9. Bir	thplace (State or Foreign buntry)
Director		N/A Usual Residence of Decedent			1 13	05-30-20	Ub Mar	yland
land		10a. State 10b. County	1	Oc. City, Town or L	ocation			10d. Inside City Limits
Many Hear	tor	Marvel and Danch		Cambridge				1 XYes 2 No
28a	Director	Maryland Dorch 10e. Street and Number	ester	Campi ruge	10f. Zip Code	10g	. Citizen of What Co	ountry?
LING X IX 13-0030 be filed within 72 hours after death with the Maryland tal Hyglene. dother than "natural", or Items 23a or 28a-1 ehow event, its Medical Examinar must be notitled at	0	514 Greenwood	J A		21613		TICA	
ms 2	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No-	USA 14. Race - Ame	
or Iter	Fur	1 Never Married 2 Married	Armed Forces?			to Rican, etc.)	Black, Whi	e, etc.
al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 XNo Specify:		Specify:	lack
2 ho	Completed	15. Decedent's E	ducation	16a. Dece	edent's Usual Occupation e kind of work done during most of wo	rting 16	b. Kind of Business	
Pan T	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retired)	King		
er giewi	5	0			N/A	N	/A	
al Hy	Be (17. Father's Name (First, Middle, Last,)		18. Mother's Nar	ne (First, Middle, Ma	iden Sumame)	
Laryland A.L.A. 2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ma	2	Willis John	son		Shyra	F	letcher	
and and is my		19a. Informant's Name/Relationship (^{Турө, Print)} Paren	ts 19b. Mail	ing Address (Street and Number or Re	<i>iral Route N</i> um <i>ber, C</i>	ity or Town, State,	Zip Code)
Defititions, INCA yield A 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 ehow any nijury or other traumatic event, the Medical Examiner must be notified at once.		Willis Johnson &		her 514	Greenwood Ave.,		Maryland	21613
of He roth		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □	Demoval from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date 20	c. Location - City or	Town, State
Page nent ent: I		'4 □Donation 5 □ Other (Specif		Capito1	Crematory 06-1	2-2006 D	over, Del	aware
Definit. Pages Department of Importent: If it any njury or o		21. Signature of Funeral Service Licer	nsee	2	2. Name and Address of Facility Bennie Smith Fune			
0 88588		Dummie S	Shaw	1.5	524 Race Street,	Cambridge	.Maryland	21613
100		23a. Fart1. Enter the disease, or com shock, or heart failure. List only	plications that caused th	e death. Do not er				Approximate Interval Between
Physician		Immediate Cause (Final	D	L - +41	124 1 ve ale	<)		Onset and Death
/Medical		disease or condition resulting in death)	a Due to (or as a	consequence :	(27 week	3)		-
Examiner		ye-	Rec D	iratory	Distress	(RDS)		the ismia
	ē	Sequentially list conditions if any, leading to immediate	b. Due to (or as a	consequence of):	7101100	(13)		The Dini
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	2	,				
exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a	consequence of):				
F.C. BOX 00 (00), that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	cal		d					
g phy as th	ed							
The law requires that the death certifical. The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		□r		23d. Date of de	livery
deatl	ICIa	in the past 12 months?	1∐Live birth 2 4☐Pregnant at tir		□Ectopic pregnancy □ Other (specify)		Month	Day Year
by the ache	hys	9 ☐ Unknown	9□ Unknown					
s tha	by P	Part II. Other significant conditions of	contributing to death but	not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
w requires to been signed should be						1 🗌 Yes	2×No 3□Pi	robably 4 Dunknown
w re s bee	Completed					24a. Was an	24b. Were at	utopsy findings available
he la e has	m.					autopsy performe	death?	completion of cause of
	Ö	25. Was case referred to medical			26 Place of Dec	1 ☐ Yes 2X ath (Check only one)	No 1 ☐ Yes	2X No
sicia s cert	o B	examiner?	Hospital: Inpatient	2 ER/Outpatie	Othor	lome 5 Residence	o 6 DOthor (Sag	0/4.)
Phy or this		27. Manner of Death	28a. Date of Injury	28b. Time	Tel mani	28d. Describe how		Cny)
ding th.	to	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day´)	(ear) Injury	Work? M 1 ☐ Yes 2 ☐ No			
r Attending Ph er death. rector: After th	Certification;	3 ☐ Suicide 6 ☐ Could not b	286. Place of injury	At home, farm, s	reet, factory, office		at and Number or Ri	ural Route Number,
after Direct	ert	4 Homicide	building, etc.	(Specify)	•	City or Town, S	State)	
apita lours neral		29a. Ceptifier Certifying Pl	nysicien: To the best of	my knowledge, dea	th occurred at the time, date and place	, and due to the caus	se(s) and manner as	s stated.
e Ho 24 P e Fu letely	edical	(Check only 2 Medicel Example)	niner: On the basis of e and manner state	xamination and/or ii	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due	to the cause(s)
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and tille of certifier			29c. License number		. Date signed (Mont	
, ,,,,,,		MAN	MO		my 21 8	8 1	-1-20	06
		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	Print)	3		
2		Loura A. On	girimp	503A	muir Street	Cambr.	dge mi	06
St	ate	31. Date filed (Month, Day, Year)	Registrar'	s Signature	4	<u> </u>	0	
Regist		JUN 0 5 200	6	B A				
		9911 0 3 301		-				

			1 - For State Registrar	State of M		Department Certificate				giene Reg. No. 2	006	19578
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Malajah N	Last) VJah Give street and number)	chnsor East	4b. City, 1	Town, or Loca	tion of Death	2. Date of Dea	3i	Year 2006 nty of Death	3. Time of Death
	Funeral Director		5. Social Security Number N/A Usual Residence of Decedent	5. Sex 7. As	ge (In yrs. last bin			nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da.	h y, Ygar) 0/2000	9. Birth	place (State or Foreign
	the Maryland 28a-f show	Director	10a. State 10b. County Maryland Dorche 10e. Street and Number	ster	10c. City, Town	ridge	Codo			10 01		10d. Inside City Limits
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23e or 28e-f show other traumatic event, the Medical Exertinet must be notified at	by Funeral	514 Greenw 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	No	1 ☐ Yes 2	21613 ent of Hispani fly Cuban, Me No Spe	ic Origin? (Spe xican, Puerto F ecify:	cify Yes or No- Rican, etc.)	USA 14. R Special Section of the s	A ace - Americ lack, White, city:	ean Indian, etc. lack
2121	filed within 72 I Hygiene. other then "no	Be Completed	(Specify only highest Elementary/Secondary (0-12) 0 17. Father's Name (First, Middle, La	grade completed) College (1-4or :		(Give kind of word life. DO NOT use N/A	k done during e retired)	most of working		N/A		dustry
Maryland	id 2 should be th and Mental 27 is markad o traumatic eva	To B	19a. Informant's Name/Relationship			Mailing Address	(Street and No		Route Numbe			
Baltimore,	Page nent o ant: if ary or		Willis Johnson & 20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 `4 □ Donation 5 □ Other (Spe	□Removal from State	20b. Place of cemeter	14 Greens Disposition (Namily, crematory or off ol Cremat	e of her <i>place)</i> tory	06-12	ate	20c. Location Dover,	n - City or To	wn, State
Bal	permit. Par Depertment Important: any Injury o		23a. Part1. Enter the disease, or conshock, or heart failure. List or	Shaw omplications that caused	d the death. Do n	524 I	ie Smit Race St	th Fune	Cambric	lge Mar	yland	Approximate
4	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as b. Res)	a consequence of	ity D	(24 istres	weel SS (rDS))		Interval Between Onset and Death
8760,	sate be executed obysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of	of): ()						
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pres					ate of delive	ry Day Year
Records, P.	w requires that been signed b should be deta	þ	Part II. Other significant condition	s contributing to death b	ut not resulting in	the underlying car	use given in P	art I.	23e. Did to			e cause of death?
ital Rec		e Completed	25. Was case referred to medical				26 P	Place of Death		med? 224No	prior to con death?	osy findings available inpletion of cause of
Division of Vital	tanding Physicath. tor: After this the funeral dir	ertification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no	t be	ry Year) 28b. T		Cther: 4 Cc. Injury at Work?	Nursing Hom	e 5 Reside	ence 6 🗆 O	irred	
Div	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	edicai Certif	CHOCK ONLY Z MEDICAL EX	building, etc. Physician: To the best ceminer: On the basis of	c. (Specify) of my knowledge.	death occurred at	the time date	e and place, an	City or Town	n, State)	anner as st	Ated.
)	To the within 2 To the complete	Med	29b. Signature and title of certifier	and manner sta	ated.	29c.	License numb		2	9d. Date sign	ed (Month, L	Day, Year)
	0		30. Name and address of person with a company of the company of th	. Orgivi	eath (Item 23a) (1021613
	Sta Registr		JUN 0 5 2006		ar a Signature	A)						

			For State Registrar	State of	Marylar		artmen				ental Hyg	iene	2006	19579
			Decedent's Name (First, Middle, Las	t)							2. Date of Deat	n		3. Time of Death
	Physici		CHARLES HAROI	LD J	ETT						Month JUNE	Day 14	Year 2006	10:15P M
	/Medic Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of		OUND	T-	ounty of Death	10.131
1	Exami		CHARLOTTE HALL VI	ETERANS	HOME				E HAI				MARY'	S
	Funeral		5. Social Security Number 6. Se			. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth			place (State or Foreign
	Director		214-28-4596	XM 2□F	7	75 Yrs.	Months	Days	Hours	Min.	(Month, Day, APRIL 5			YLAND
	p		Usual Residence of Decedent									, 1/-	71 11111	I DIMID
	ehow		10a. State 10b. County		10c. C	ity, Town or Lo	cation						1	0d. Inside City Limits
	e Ma	cto	MD ST. MARY'	S	CHA	RLOTTE	HALL							1 ☐ Yes 2 🛣 No
	th th	Jire	10e. Street and Number				10f. Zip	Code			10	g. Citizer	of What Cour	ntry?
	within 72 hours after deeth with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow the Madical Exeminer cust be notified at	Funeral Director	29449 CHARLOTTE H	IALL ROA	D			2062	2			U	J. S. A	•
	eep .	ner	11. Marital Status	12. Was Deced	as?	J.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	city Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
98	or it	Ī	1 Never Married 2 Married	1 ⊠Yes 2	2 □ No		1 ☐ Yes 2			.,		C		etc.
21215-0036	ireli,	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	es: '48-	. '51			opcomy.			3,	WHI:	ГЕ
5	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation during most	t of workir	ng 1	6b. Kind	of Business/Inc	dustry
2	hen n	ם	Elementary/Secondary (0-12)	College (1-	4or 5+)									
7	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Ma		8			MECHA	NICAL	ENG					DAIRY	
2	be fi	Be	17. Father's Name (First, Middle, Last) CHARLES JETT					ŀ			(First, Middle, N	laiden Su	mame)	
7 3	should ind Men imarke umarlic	ို									OSWELL			
Maryland	s 1 and 2 should be filed within 72 hours after deeth with the Maryla of Heelth and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23s or 28s-1 ehoy other traumatic event, the Mydical Examiner must be notified at		19a. Informant's Name/Relationship (7	ype, Print)							Route Number,			
	and leelth m 27 her tr		LINDA S. POTTER /	DAUGHT					TCH R		.O.B.231			
Baltimore,	permit. Peges 1 and 2 Department of Heelth ar Important: If Item 27 is eny injury or other trau <u>once</u> .		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from S		Place of Dispo cemetery, crei	nsition (Nam natory or of	ne of ther place	9)	D	ate 2	0c. Locat	tion - City or To	wn, State
Ë	men men tant:		4 □ Donation 5 □ Other (Specify			INSFIE	LD-ECI	HOLS	CR.J	UNE	16,06	HARL	OTTE HA	ALL, MD
Sall	Depentit. Depentit Importe eny inju		21. Slowe ure of Funeral Service Licens	See SC 1/	_	22	2. Name and	d Addres	s of Facilit	y BRI	NSFIELD-	ECHO	LS FUNI	L.HME.,P.A.
_	20229		23a. Part 1. Enter the disease, or comp	a John	Commence of the last		_				D CHARLO		HALL, N	ID 20622
90,	Physician /Medical Examiner the pniar-transil	l Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	r as a consecuras a consecurada a	quence of):	HRON	NC	UBS	STRU	ocong Ri	Mn Oi	ARY	Onset and Death
8760,	5 S S	dlcal	•	d										
P.O. Box 6	ne death certifi the ettending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Feta	al death 3	Ectopic pre Other (spe					23d	. Date of delive Month	ry Day Year
	res thet the igned by be detact		Part II. Other significant conditions co	ntributing to dea	th but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did tobi	acco use	contribute to th	e cause of death?
sp	urres 1 sign 1d be	d b	CORONARY (787400	019	SARS					12 Yes	2 🗆 N	lo 3 ☐ Prob	ably 4 □Unknown
of Vital Records,	w requir been s should	Completed by	9001150015	() 0 1)	0	,				24 14	- 1-		
Re	hes hes	ם	15449116	CITA	110119	SP.4711	7			_	24a. Was an autopsy perform		4b. Were autor prior to con death?	osy findings avaitable appletion of cause of
a												No		2□ No
Ž.	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medicat examiner?	Hospital:				04-		of Death	(Check only one)		
o	Phys this aldii	ုင	1 162 5 140	1 🗆 In		ER/Outpatier			411-14901		e 5 🗆 Resider)
2		0	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of (Month	Day Year)	28b. Time of Injury		Bc. Injury Work		_	8d. Describe how	v injury o	curred	
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be				М		res 2□t					
Ξ	after of Direction by	틭	4 Homicide determined	28e. Place of building	f Injury · At h g, etc. <i>(Speci</i>	iome, farm, str fy)	eet, factory,	, office		2	Bf. Location (Street, City or Town,	et and N State)	umber or Rura	Route Number,
Ц	To the Hospitel or Attsnowithin 24 hours after death To the Funeral Director:			1										
	Hoss 4 ho Fund Fund	edicai	29a. Certifier 1 Certifying Phy	iner: On the bas	is of examina	owledge, death	occurred a vestigation.	in my on	e, date and	d place, au	nd due to the car d at the time, da	use(s) and	d manner as sta	ated.
	To the Hospite within 24 hours To the Funeral completely filled	Med		and manne	er stated.									
	5 T W T 0		29b. Signature and title of certifier		1	_ ^	29c.	License	number	/	29	a. Date si	gned (Month, L	JUNE 15 20
,	1 - 1 -			5/1/2	wir	1.1),	W 0	1056	575	2	06	15/2	006.
1	+ NV		30. Name and address of person who c					_					/	
			Naznin Esphani,				koad,	Pri	nce F	rede	rick, MD	206	78	
	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Sign	ature								

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Theresa L. Johnson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		- For State		Certif	icate of i	Death		F	Reg. No.	200	10	1930
Physicia		Registrar 1. Decedent's Name (First, Middl	rst, Middle,Last) 2. Date of Death 3. Time of Death									ne of Death
ledical Examir		Teresa Lynn Jo	hnson					Month June 14,	Day 2006	Year	18	50 hrs
		4a. Facility Name (if not institution	n, give street and n	umber)	4b	City, Town, or Lo	cation of Death			ounty of Deat	th	
		116 Kirk Road	-			Perryville			Cec	ál		
E		Social Security Number	6. Sex	7. Age (In yrs. last	birthdav)	If Under 1 Year	If Under 24Hrs	s. 8. Date of B	rth(MM/DD/	YYYY) 9. B	irthplace	(State or
Funeral Director		5. Social Security Number		, , igo (iii yio. iao.	z. a. rauy /	Months Days	Hours Min	1.		Forei	ign	
Birector		213-66-6206	1 M 2 X F		50 Yrs.	1.4		June	2, 19	56	ountry)	DE
	F	Usual Residence of Decedent		140- Oit -	un as l acci'-						104	nside City Limits
w any.		10a. State 10b. County			wn or Location							Yes 2 X No
and shov	5	MD Ceci	l	Perr	yville							I LES Z NO
Aaryland 28a-f show 1 at once.	18	10e. Street and Number		<u> </u>		10f. Zip Code			10g. Citizen	of What Cou	untry?	
AD 21215-0036 2 should be filed writhin 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Director	116 Kirk Road				21903		1	USA			
rith t		11. Marital Status	12. Was De	cedent Ever in U.S.	13. Was	Decedent of Hispa	anic Origin? (S	pecify Yes or N		Race - Ame	rican In	dian, Black,
ath v	Funeral	1 Never Married 2 X M	arried Armed F		If Yes	s, specify Cuban, I	Mexican, Puerto	Rican, etc.)		White, etc.		
er de		3 Widowed 4 Div	1 Yes	2 X No	1 ,	Yes 2 X No	specify:		Spe	ecify: Wha	ito	
rs aft	ā.	15. Decedent's Education (Spe	or Dates:			s Usual Occupatio		work done		of Business		у —
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36 in 72 han '	be		Conego	(140,01)	(1)				-	,		
withi iene.	틹	12 17. Father's Name (First, Middle	1		Waitr	<u>ess</u>	Mother's Nam	e (First, Middle,	Food	d name)		
Hyg thoth									Maidel Sui	name)		
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Be	Laurence R. Ch	arsha		406 44-16		Eleanor			- T Ct	- 7:- O	(-4-)
2 2. hould hould sid Miss miss miss miss miss miss miss miss	ို	19a. Informant's Name/Relations				Address (Street						
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		Walter Daniel	<u>Johnson</u>		<u>116 Ki</u>	rk Road.	Perry	<u>ille. N</u>	D = 21	903		01-1-
Heal		20a. Method of Disposition	a 2 Demayal		ce of Disposit matory or othe		etery, 06-	Date 19-2006	20c Loca	ation - City o	or Iown,	State
ages nt of nt: If		1 Burial 2 XCrematio					Hame	D A	Ris	ina Si	ın	MD
ti Pritmentumentan		4 Donation 5 Other S 21. Signature of Funeral 35 ice	a Licens		22. Na	Funeral ame and Address of	f Facility D	T Tork	J T	ora l	lama	D A
Balti permit Departn Imports injury o					11	1 8 040	on St	Pi inc	a run	WD '	10me 2191	, P.A.
	-1	23a. Part I Emer the disease, o	r complications that	caused the death. D	o not enter the	e mode of dving, s	uch as cardiac	or respiratory a	rest. shock.	or heart		roximate Interval
Physician /Medical	1	failure List only one cause	on each line.				0011 00 001 0100		, , , , , , , , , , , , , , , , , , , ,			ween Onset and
Examiner		Imme hate Cause (Final dis - se		ations of co	ocaine u	se						Death
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P.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transi	E	X UNPENDED		item#1,23	a 27 ner	MF 9856 6	/30/06 111	1			\top	
be e.	n/Medical		7=-144			,1 kL , g0.00 , 0,	/50/00 11		-			
8760, ifficate b	ž	IF FEMALE: 23b. Was decedent pregnant in t		s, outcome of pregna		al death 3	Ectopic pregr	anov		ate of delive onth	ery Day	Year
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Box 68 e death certi	sic	1 Yes 2 No 9 🗸 Ur	alknessen	nown	5 Uth	er (Specify)						
. B y the de	Physicia	Part II. Other significant cond			ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute t	to the ca	use of death?
P.O.		Tartin. Outer significant conta	dono commodning	to doddin bar nor root	anning in the an			1 TY	es 2 N	lo 3 Pr	obably	4 V Unknown
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e law e has ge 2 s	Ē							1 ✓ Yes	formed? 2 No	death?		2 No
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certiful the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a		25 Was case referred to media	eal .			26 Place	of Death (Check			. 🔻		
tal lician: certifi	Be	25. Was case referred to medic examiner?	Hospital:	Inpatient 2 E	R/Outpatient		N	ing Home 5	Residence	e 6 🗸 Oth	er Scer	10
FVi Physi er this	ဥ	1 Yes 2 No			28b. Time of Ir		at Work?	28d. Describ			.51. 0081	-
1 of Jing Ph Jing Ph After t funeral		27 Manner of Death 1 X Natural 5 Page	(Mor	nth, Day,Year)	ob. Time of it		_	200. Describ	5 HOW HIJOLY	occurred		
ion tend eath.	aţic		nding estigation				es 2 No					
ViS or At ther d birect in by	iţi		uld not be 28e. Pla	ace of Injury - At hom	ne, farm, stree	t, factory, office bu	ııldıng, etc.	28f, Location or Town		Number or F	Rural Ro	oute Number, City
Divisitate of training the control of the control o	Certification:		ermined (Specif	5y)				J or rown,	Otate)			
losp 4 hou une			Physician: To the b	est of my knowledge	, death occur	red at the time, dat	e and place, ar	nd due to the ca	use(s) and n	nanner as st	arted.	
To the Howithin 24 For the Function completely	<u> </u>	one) 2 Medical Ex	aminer: On the basi	is of examination and	d/or investigat	ion, in my opinion,	death occurred	at the time, da	te and place	, and due to	the cau	se(s)
To with To corr	Medical	29b. Signature and title of certif	and manner fier	ı stated		29c. License	number		29d Dat	te signed (N	Aonth, D	ay, Year)
		N. T	7			O.C.N			June	15, 2006		
		anet				0.0.1				. 3, 2000		
		30. Name and address of person					. ND 040	04				
			ssistant Medica	ıı ⊵xaminer 1	11 Penn S	treet, Baltimo	re, MD 2120	U I				
S	tate	31. Date filed (Month, Day, Yea JUN 1 9 20	7) 32.	Registrar's Signature	hout !	,						
Regis	trai	JUN 1'9 20	Ub Block	W SU A								

	State of Maryland / Department of Health and M 1- State Registrar Certificate of Death	ental Hygiene 006 9582
Physician	Decedent's Name (First, Middle, Last) Harry Wayne Jordan	2. Date of Death Month Day Year 5 29 2006 6 00 A M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) BALLimore VA Medical Center BALLimore	4c. County ol Death
Funeral Director		8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Foreign Country) NOV. 18, 1935 Pennsylvania
anyland show	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Arnold	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
with the Maryla a or 28a-1 sho	10e. Street and Number 10f. Zip Code 21012	10g. Citizen of What Country? USA
d 21215-0036 d 21215-0036 light with 72 hours after death with the Maryland Hygiene, wither than "natural", or Items 23a or 28a-1 show ont, the Medical Evantinar must be notified at a Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto 1 ☑ Yes 2 ☑ No If Yes, Sive 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No	ncify Yes or No-Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 that 2 should be filed within 72 hours at all and Mental Hygiene. 27 is marked other than "natural", or retreumatic event, the Medical Event To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work) Iffe. DO NOT use retired) Technician	16b. Kind of Business/Industry Electronics
Te, Maryland 2121 s 1 and 2 should be liled within theath and Mental Hygiene. Item 27 is marked other than other treumatic event, the M		(First, Middle, Maiden Sumame) ne Shevock
Mary	19a. Informant's Name/Relationship (Type, Print) Garnett Goughenour/Sister 19b. Mailing Address (Street and Number or Rural 402 Howard Avenue	Route Number, City or Town, State, Zip Code) Arnold, MD 21012
4. 4 9 E 2		Date 20c. Location - City or Town, State
Baltimore permit. Pages 1 Department of H important: If Its sny injury or ott	21. Signature of uneral Services (Jensee) 22. Name and Address of Facility Barranco & Sons, P. 495 Gov. Ritchie ht	
Vision of Vital Records, P.O. Box 68760, Attanding Physician: The law requires that the death certificate be executed in death. Attanding Physician: The law requires that the death certificate be executed in death. Attanding Physician: The law requires that the death certificate be executed in the law law law law law law law law law law	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, of heert lailure. List only one cause on each line. Immediate Cause (Final disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): r respiratory arrest, Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68 after and and Physician: The law requires that the death certifical after death. Director: After this certificate has been signed by the attending play the funeral director, page 2 should be detached for use as a fin by the funeral director, page 2 should be detached for use as a certification; To Be Completed by Physician/Mec		23d. Date of delivery Month Day Year
rds, P. quires that the nation signed by and be detacted by Physical By Physical Phy		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown
al Records, The law requires th cate has been signe page 2 should be c		24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
of Vital Re- Physician: The la rthis certificate has ral director, page 2	25. Was case referred to medical examiner?	(Check only one)
ion of \nding Physi	1 Pres 2 No 1 Prinpatient 2 ENOutpatient 3 DOA 4 Nursing Ho	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After I completely filled in by the funeral Medical Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
o the Hospit thin 24 hours ompletely fills Medical (and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier 29c. License number P19714	29d. Date signed (Month, Day, Year) 05 29 2006
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUN RET GAND TRAIND 10 NORTH GREENSTREET	
State Registrar	31. Date liled (Month, Day, Year) JUN 0 5 2006 Registrar's Signature	

			For State Registrar	State	of Marylan		artment of F rtificate of		_	giene 0	06	195	583
	DI		1. Decedent's Name (First, Midd	le, Last)					2. Date of De Month	ath Day	Yeer	3. Time of	Death
	Physici /Medio		Jean R.	Johnson			,		June 1	, 2006		6:32	РМ
	Examin	er	4a. Facility Name (If not institution		um <i>ber)</i>			or Location of Deat	h	4c. County	of Death		
			Suburban Hos	oital 6. Sex	7. Age (In yrs.	last hinth day	Bethes		9 Date of Rin	Montg		y lace (State o	or Corning
	Funeral Director		5. Social Security Number 579-62-6986	1 M 2 X F	97	Yrs.	Months Days	Hours Min.	(Month, Da	ly, Year) 28, 1909	Coun	try)	ir r-ureign
			Usual Residence of Decedent						April	20, 1905	Neb	raska	
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10	0d. Inside C	
	88-1 o	Directo	Maryland Monte	omery	В	ethesd.							2 No
	with the		10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?	
	eeth ye 23	Funeral	9707 Old Geor		cedent Ever in U	S. 13	20814 Was Decedent of H	Hispanic Origin? (S	Specify Yes or No	U.S.	A - Americ	an Indian.	
	ă ≗ ≅	F	1 Never Married 2 Mar	Armed F ried 1 ☐ Yes	Forces? 2 [X]No		If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		k, White,		
35	buts after deeth with the Marylan elf, or Iteme 23e or 28e-1 ehow Exercirer must be notified at	þ	3	If Yas C	Sive Dates:		1□Yes 2⊠No	Specify:		Specify	Wh	ite	
יר ר	within 72 hours after ene. than "neturel", or Ite	Completed		nt's Education	1)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wo	rking	16b. Kind of Bu	siness/Ind	dustry	
5	within ne. then	gu	Elementary/Secondary (0-12)	College	(1-4or 5+)		do no ruse retire Homemaker			0	•		
7	Hygie Ther and	ပိ	12 17. Father's Name (First, Middle,	Last)			тошешакет		me (First, Middle	Own I Maiden Sumam			
2	d be ental ked o	To Be	George Redic					Marion	Hughes				
Maryland 21215-0036	shound M	-	19a. Informant's Name/Relation			19b. Mailie	ng Address (Street			er, City or Town,	State, Zip	Code)	
Ž	and 2 alth a		W. Stanfield J	ohnson		5715	Bent Bra	och Ed Be	ethesda.	Marylar	d 20	81.5	
9	of He Control		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from	n State	Place of Disponentery, crea	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or To	wn, State	
Ě	Ment and a grant		4 Donation 5 Other (L Cremato		e 6,06	Falls Ch	urch	. Va.	
Rollimore	permit. Pages 1 and 2 should be filed within 7 bepartment of Health and Mental Hygiene. Importent: If Item 27 ie marked other than "nevy injury or other traumatic event, in the base.		21. Signature of Funeral Service	Licensee		22	2. Name and Addre	ess of Facility Jos	seph Gaw	ler's So	ns,	INC.	
ï	4 40504		23a, Part1. Enter the disease, of	K, Pu	request the deat		30 Wisco				n D.	C. 200 Approximat	
			shock, or heart failure. Lis	t only one cause on	each line.	TI. DO NOT ON	ter trie mode or dy i	ng, 30011 23 021 012	o or respiratory a	11031,		Interval Bet Onset and I	ween
	Physician /Medical		disease or condition resulting in death)	a. Oue to	Pneum o (or as a conseq	othora	ıx						
3	Examiner				0 (01 43 4 0011304	derice ory.							
w		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	o (or as a conseq	uence of):							
18	death certificate be executed death certificate be executed e attending physicien and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
90	cien a		resulting in deathy case	Due to	o (or as a conseq	uence of):							
90/	physicate sthe t	Physician/Medical		d									
19	eath certificate attending pl	√Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		×11			23d. Dat	e of delive	rv.	
à	death a atter d for u	iciar	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pre	obirth 2 □ Feta gnant at time of d		⊒Ectopic p reg nanc ⊒ Oth <i>er (specify)</i> _	у		Mor		•	Year
2 0	by th	hys	9 Unknown	9∐ Unk	nown								
60		by P	Part II. Other significant condit	ions contributing to	death but not res	ulting in the u	ınderlying cause gıv	ven in Part I.	23e. Did t	obacco use contr	ibute to th	e cause of o	leath?
12	w requires been sign should be								10	Yes 2□No	3 Proba	ably 4 □l	Jnknown
Juson Just	e law r has be	Completed							24a. Was	an 24b. V	Vere autop	osy findings inpletion of c	available ause of
000	ysician: The lis certificate hadirector, page	Co							1 ☐ Yes	rmed? d 2 No 1	Yes	2□ No	
24	Physician: The Physician: The Physician The Physician The Physician The Physician Phys	Be	25. Was case referred to medical examiner?	Hospital:			O#	200	ath Check only		_		
Ohnson	Physical displays	2	1 ☐ Yes 2XXNo 27. Manner of Death	16		ER/Outpatier 28b. Time o	III JUDON	4 🗆 Huising r		dence 6 Other		')	
17	Attending of r death.	tio	1X Natural 5 Pendi 2 Accident invest	ng (Ma igation	e of Injury onth, Day Year)	Injury	Wo	rk?]Yes 2∐No					
	of or Attend after death Director: /	iffice	3 ☐ Suicide 6 ☐ Could	nined 286. Plac			reet, factory, office		28f. Location (Street and Number	er or Rura	Route Num	ber,
Ĉ	s after of or or or or or or or or or or or or or	Certification;	4 D Nomedo	Odii	ding, etc. (Specif	· · · · · · · · · · · · · · · · · · ·			City of 10	wii, Statej		-2	
	To the Hospital or Attending Physician 2 or Attending Physician 24 hours after death. To the Funeral Director: Attenth completely filled in by the funeral	ledicai	29a. Certifier 1 □ Certify (Check only one)	ng Physician: To the I Examiner: On the and ma	he best of my kno basis of examina anner stated.	owledge, deat ation and/or in	th occurred at the traverstigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stand due to	ated. the cause(s	.)
	Fo the	Me	29b. Signature and title of certifi				29c. Licens	se number		29d. Date signed	(Month, L	Day, Year)	
	ylog) CAL	en	197		D262.	59	11.	June 2,	2006		
	M.		30. Name and address of person	who completed	e of death (Iter	п 23а) (Туре,	Print)						
			Ava A Kaufman				ve. #103	Betheso	la, Mary	land 208	14		
	Sta Regist		31. Date filed (Month, Day, Year	2006	Registrar's Signa	L L	SALL						
	ricgist	421	JUN 6	2000	TELLED SO	-							

			For	artment of Health and Mental Hyg	
美	Physici		1- State Registrar 1. Decedent's Name (First, Middle, Last) Daniel Albert Johnson, Sr.	rtificate of Death 2. Date of Dea Month June	Reg. No.
	/Medic Examin	-14	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Elkton	4c. County of Death Cecil
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 222-03-1661 1 2 91 Yrs.	If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month), Day Hours Min. May 24	(, Year) Country)
P	aryland	J.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the M Sa or 28a-f I be notified	Director	MD Cecil Ches. 10e. Street and Number 268 Bethel Cemetery Road	apeake City 101. Zip Code 21915	10g. Citizen of What Country?
920	s I and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "naturel", or Iteme 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2√2 № 0	Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XXNo Specify:	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	i within 72 ho liene. r then "naturi i're Madical I	Completed	(Specify only highest grade completed) (Give life.	dent's Usual Occupation kind of work done during most of working DO NOT use retired) ry Farmer	16b. Kind of Business/Industry Agricultural
Maryland ?	2 should be filed within n and Mental Hygiene. 'ie marked other then "raumatic event, the Men	To Be C	17. Father's Name (First, Middle, Last) George L. Johnson	18. Mother's Name (First, Middle, Florence H. J	ohnson
	is 1 and 2 sho of Health and item 27 ie m other traum			ng Address (Street and Number or Rural Route Number Box 42, Chesapeake sition (Name of Date	
altimore,	Pagenent o		© Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	matory or other place)	Chesapeake City, MD
Ba	Depertmit. Depertmit. Importa eny inju		23a. Part 1. Enter the disease, or complications that cav ed the death. Do not enter shock, or heart failure. List only one cause and line.	lletown, DE 19709	
	Physician /Medical Examiner	8	Immediate Cause (Final disease or condition resulting in death) a	Onset and Death	
68760,	ate be executed sysiclen and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaste of hydrothat initiated avents resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):		
P.O. Box 68	The law requires that the death certificate be e ate has been signed by the ettending physiclen page 2 should be detached for use as the buring	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Records, P	aw requires that is been signed b 2 should be deta	Completed by Pi	Part II. Other significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting in the under the significant conditions contributing to death but not resulting to death b	, , , , , , , , , , , , , , , , , , , ,	
of Vital Re		Be Com	25. Was case referred to medical examiner?	perfor 1 ☐ Yes 26. Place of Death (Check only or	med? death? 2. No 1 ☐ Yes 2 ☐ No
Division of \	Attending Physician: It death. ector: After this certific by the funeral director.	edical Certification: To	1	f 28c Injury at 28d. Describe h Work? M 1 \(\text{Yes} 2 \subseteq No \)	lence 6 Other (Specify) low injury occurred Street and Number or Rural Route Number.
Div	spital or A lours after neral Direction by	al Certif	4 Homicide determined 238. Place of my knowledge, deat 299. Certifier Certifying Physician: To the best of my knowledge, deat	City or Tow	rn, State)
	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medic	(Check only a Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	vestigation, in my opinion, death occurred at the time, o	date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
11	0)	1:0	30. Name and address of person who completed cause of death (Item 23a) (Type,		06/07/2006.
1	NS Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Street, Elkton, MD	21921
DI	IMH 17 Rev 1/2	\$ 40	JUN - 9 2006 ORIGI	NAL NAL	

		_	For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment <i>tificate</i>			nd Mer		giene 10g. No. 2006	19585
	Physicia		Decedent's Name (First, Middle, Wilmer	Richard		Jones					Date of Dea Month	Day Year	3. Time of Death 0/25 M
	/Medic Examin		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, 1	Town, or t	ocation of	Death	Ju. 42	4c. County of Dea	th
			PENNSYLA REGIO		MIL I	MADE	/	54	4504	191		Nich	
Ī	Funeral Director	1	212-12-3653	6. Sex 1⊠ M 2□ F	7. Age (In yrs. 86	. last birthday) Yrs.	If Under Months	Days	Hours	Min. 8.	Date of Birth Month, Day	9. Bir (, Year) 9. Bir (Co Ma	hplace (State or Foreign puntry) ryland
	and bw	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation				4		10d. Inside City Limits
	Mary In the	ţo	Maryland Wic	omico		Salisb	ury						XX Yes 2 ☐ No
	or 284	Oirec	10e. Street and Number		1		10f. Zip				1	10g. Citizen of What Co	ountry?
	ath w	rai	907 Spring A			10		1804		.0.101	Mar and a	USA 14. Race - Ame	ina Indian
920	urs after de al', or item xeminer o	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Woo Chu	ces?		was Deced f Yes, spec 1 ☐ Yes 2	ify Cuban	Specify:	Puerto Rica	Yes or No- in, etc.)	Black, Whit	
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show important: If Item 27 is marked other than "natural", or Itema 20 en culting a page. Once.	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		4or 5+)	(Give	dent's Usua kind of word DO NOT us	k done du		of working		16b. Kind of Business, Petroleum	,
Maryland 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, L Wilmer Jones	ast)							rst, Middle, Morris	Maiden Sumame)	
Mary	nd 2 sho alth and 1 27 is ma r trauma	i 8	19a. Informant's Name/Relationsh David Jones/son									r, City or Town, State, 2 ID 20721	Zip Code)
Baltimore,	Pages 1 e nent of Hea int: If item iry or othe		20a. Method of Disposition 1	3 □Removal from S ecity) Entombi	State T	Place of Dispo cemetery, crer WICOMIC	natory or ot	her place	1	Date 6/8/06		20c. Location - City or Salisbury	
Balti	permit. Depertrimporta eny Inju		21. Signature of Funeral Service L	icensee	SP	22 H	ol low	ay f	uhera ill R	l Home	e Prof	essional A ry, MD 218	ssociation 04
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	only one cause on ea	ach line.							rest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (c	uf 46 or as a conse	penil nuence of): plas quence of):		ter	er	1	4.		
	pe	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or as a conse	quence of):	+f(ym	ano	me		
,092	ate be executed hysicien and the burial-transit	cai Exar	that initiated events resulting in death) Last	c	or as a conse	quence of):				· · · · · · · · · · · · · · · · · · ·			
89	ificate g phys as the			d									
.O. Box	res that the death certifica igned by the ettending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2∏Fet antattime of	al death 3	Ectopic pre Other (spe					23d. Date of del Month	ivery Day Year
<u>α</u>	The law requires that the site has been signed by the bage 2 should be detache	þ	Part II. Other significant condition	ns contributing to de-	ath but not re	sulting in the u	nderlying ca	ause giver	n in Part I.			bacco use contribute to	the cause of death?
of Vital Records,	e law require has been sig je 2 should b	Completed									24a. Was a autops	sy prior to	utopsy findings available completion of cause of
lal		e Co	25. Was case referred to medical	_					06 Place -	of Dooth (C)	1□ Yes	2ENo 1 ☐ Yes	2□ No
<u> </u>	w =	To B	examiner?	Hospital:	patient 2	☐ ER/Outpatier	nt 3□ DO	Other	~		heck only or 5 □ Resid	ence 6 ☐Other (Spe	cify)
ion of	After After fune		27. Manner of Death 1		f Injury h, <i>Day Year)</i>	28b. Time of Injury	M 28	8c. Injury Work		28d.		ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	al or Atte s efter des l Director d in by th	Certification:	3 Suicide 6 Could n 4 Homicide determin	ned 286. Place	of Injury - At I	nome, farm, str	eet, factory	, office		28f.	Location (S City or Tow	treet and Number or Ro n, State)	ural Route Number,
	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying (Check only one)	g Physicien: To the exeminer: On the ba and mann	sis of examin	lowledge, death lation and/or in	n occurred a vestigation,	at the time in my opi	e, date and nion, death	place, and occurred a	due to the c	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To th withir To th somp	W	29b. Signature and title of certifier	M			29c	License	number		2	29d. Date signed (Mont	h, Day, Year)
}	DE							005	73:	33		6/5/06	
1	Polly		30. Name and address of person v	no completed cause	or death (Ite	_	Print)	n	5ho	he 1	SA .	Salisbr	m, M)2180j
	Sta Registr		31. Date filed (Month, Day, Year)	32. 1	gistrar's Sign		rosti s	,					

			Plea 1 - State Registrar	ase Type or State o	Print in B	d / Depa		t of H	ealth a		lental Hy		egible.	19586
	Physici /Medic		Decedent's Name (First, Midde ANNIE Z. KE								2, Date of Dea Month MAY	_	2006	3. Time of Death 7:30AM M
	Examir		4a. Facility Name (If not institution TALBOT HOSPI		mber)		E	ZASTO				4c. Co	ounty of Death	
	Funeral Director		5. Social Security Number 224–24–2644	6. Sex 1 ☐ M X ☐ F	7. Age (In yrs. I	last birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da APR 25	h y, Ye <i>ar)</i> 1917	9. Birth Con VIR	nplace (State or Foreign Intry) GINIA
	e Maryland Be-f show	ctor	Usual Residence of Decedent 10a. State 10b. Count MD TA	LBOT		, Town or Lo		S						10d. Inside City Limits 1 Yes 2 □ No
	th with th	Funeral Director	10e. Street and Number 203 SEYMOUR A	WE.			10f. Zip		663			10g. Citizer	of What Cou	untry?
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28e-f show or other traumatic event, the Medical Evanti wir mat be incitified at	by	11. Marital Status 1 Never Married 2 Ma 3 X Widowed 4 Divorce	Armed Formarried 1 Armed Formarr	ve	1	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	in? (Spe , Puerto	ecify Yes or No Rican, etc.)		Race - Amer Black, White	, etc.
21215-0	within 72 h ene. than "natu	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12			(Give life.	dent's Usua kind of woi DO NOT us	al Occupa rk done d se retired	ation Juring most)	of worki	ing		of Business/I	ndustry
land 2	12 should be filed within h and Mental Hygiene. 7 is marked other than "	To Be Co	17. Father's Name (First, Middle DANIEL CLEVELA		1AN	NU	URSE				(First, Middle,	Maiden Su	DICAL mame)	
Maryland	and 2 shorestith and N m 27 is mai her traumai		19a. Informant's Name/Relation ROGER KELLER/S								CORDOV			ip Code)
a)	Pages 1 a nent of Hea ant: If item ury or othe		20a. Method of Disposition 1		State C	lace of Dispo emetery, crer	osition (Nan	ne of ther plac	θ)	С	5/2006	20c. Locat	ion - City or 1	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service		CCE Ros	_ FF	2. Name an ELLOWS	5. H	LFENI	BEIN	& NEWN EASTON,	AM FUI	NERAL 1	HOME PA
	Physician /Medical Examiner		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that stonly one cause on a.	caused the death	Do not ent	ter the mod	e of dying	g, such as o	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	secuted and I-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	1 c	(or as a consequ					_				
P.O. Box 6	that the death certificate be executed by the attending physician detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live I	tcome of pregna birth 2 ☐ Fetal nant at time of de lown	death 3	Ectopic pro					23d	. Date of delive Month	rery Day Year
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of	Physician: r this certifica ral director,	To B	examiner? 1 Yes 2 No 27. Manner of Death	Hospital:		ER/Outpatier		Bc. Injury	^{or:} 4□ Nur	sing Hor		ence 6 🛚		(b) HOSPICE
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 □ Could	d not be 28e. Place	of Injury hth, Day Year) of Injury - At ho ing, etc. (Specify	Injury me, farm, str	М	Work	.?` ∕es 2□N	lo		treet and N		al Route Number,
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	To the He within 24 To the Fe completel	Me	29b. Signature and title of certifi	5 MUS	Shires	L. W.	290	License	number	23		29d. Date si	gned (Month,	Day, Year)
	(-1/1/4)		30. Name and address of perso	n who completed caus	se of death (Item	23a) (Type,	Print)				1			

Registrar

DHMH 17 Rev 1/2001

State

DESHIELDS, MARY S. M.D.

509 IDLEWILD AVE., EASTON, MD 21601

06-04055 Joseph Earl King

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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, ,		1- For State Registrar	Cer	tificate of L	Death		Re	g. No.	16 1958		
Physicia	n/	Decedent's Name (First, Middle,Last)					2. Date of Death		3. Time of Death		
ledical Examin		Joseph	Earl	Ki	.ng		June 12, 2	006	1405 hrs		
		4a. Facility Name (if not institution, give st		1	. City, Town, or Locat Glen Burnie	tion of Death		4c. County of Dea Anne Arunde			
- Marie		Baltimore Washington Medic	7. Age (In yrs. Ia			Under 24Hrs.	lo Data of Right				
Funeral Director		5. Social Security Number 6. Sex				lours Min.		h (MM/DD/YYYY) 9. B Fore	ign		
Director	ļ		2 F 47	Yrs.			Aug. 3	, 1958 °	Country) MD		
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	1				10d. Inside City Limits		
	.	MD Anne Arun	del (Crownsvi	116				1 Yes 2 No		
Aaryland 28a-f show 1 at once.	턍	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	41		
or 28	Director	1021 Generals High	wav		21032			USA	7		
death with the Maryland or items 23a or 28a-f sho must be notified at once.	eral	<u> </u>	2. Was Decedent Ever in U.	S. 13. Was	Decedent of Hispanic	Origin? (Spe	ecify Yes or No-		erican Indian, Black,		
eath r	nue	1 Never Married 2 Married	Armed Forces? Yes 2 X No	If Yes	, specify Cuban, Mex	ican, Puerto I	Rican, etc.)	White, etc.			
ifter d	by F	3 Widowed 4 X Divorced If N		1 Y	es 2X No spe	ecify:		Specify:	White		
ours a		15. Decedent's Education (Specify only h	nighest grade completed)		Usual Occupation (G			16b. Kind of Business	s/Industry		
6 n 72 h an "n	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)				ou,				
5-0036 led within 7 Hygiene. l other than	Ē	12 17. Father's Name (First, Middle, Last)		Equipme	nt Operato		75	Sand and	Gravel		
filed Hyged of	Be C	Robert J. King						taiden Sumame)			
2121 ould be fi Mental marked ic event,	일	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailing A		irley I		ber, City or Town, Sta	te. Zip Code)		
MD d 2 shoulth and is a 27 is a numatic		Robert J. King (Fa	ther)					ownsville,			
Dre, MD 21215-003 set I and 2 should be filed withi of Health and Mental Hygiene If item 27 is marked other ti her traumatic event, the Me		20a. Method of Disposition	20b. F		on (Name of cemeter)		Date	20c. Location - City of			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itani: If item 27 is marked other than "natural", or items 23a or 28a-fate or other traumatic event, the Me Meal Examiner must be notified at once		1 X Burial 2 Cremation 3 Donation 5 Other Specify:	Itemoval nom State	•		146 6-	16-2006	Millerew	illa MD		
	4 Donation 5 Other Specify: Our Lady of the Fields 6-16-2006 Millersvill 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A.										
iii ji ge aa	1 12 Ridgely Avenue, Annapolis, MD 2140										
Physician		23a. Part I. Enter the disease, or complica failure. List only one cause on each		Do not enter the	mode of dying, such	as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and		
M di al	١	Immediate Cause (Final disease a. A	theroslcerotic o	cardiovasc	ular disease	with c	nolicatio	ns.	Death		
Administra		or condition resulting in death)	e to (or as a consequence of	f):					11		
F	-	Sequentially list conditions, if any, leading to immediate b	e to (or as a consequence of	F)·							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	,								
is d	Xar	events resulting in death) Last	e to (or as a consequence of	f):							
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O, e be e: /sicial burial	Medica				,go <i>31</i> ,7/27/0	0 11					
8760, ifficate be ng physici us the buri		23b. Was decedent pregnant in the	23c. If yes, outcome of pregr		I death 3 Ec	ctopic pregnar	ncy	23d. Date of delive Month	ery Day Year		
Box 687 death certific the attending p	ician/	past 12 months?	Pregnant at time of de	ath	r (Specify)				,		
Bo e deat the at	Physi		9 Unknown								
of Vital Records, P.O. Box 68: g Physician: The law requires that the death certifi ther this certificate has been signed by the attending neral director, page 2 should be detached for use as I	by P	Part II. Other significant conditions co	ntributing to death but not re	esulting in the un	derlying cause given i	in Part I.		bacco use contribute t	o the cause of death? obably 4 Unknown		
ords, P.C w requires that as been signed b											
cord law req has bee	ompleted						24a. Was a autops	sy prior to	autopsy findings available completion of cause of		
Rec The la	E						perform 1 V Yes 2				
Vital Rec ysician: The B his certificate director, page	Be C	25. Was case referred to medical examiner?			26.Place of De		only one)				
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_ ≛ . ⋖ ∉	Ë	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj			28d. Describe h	ow injury occurred			
isior Attencer death rector: by the	atic	2 Accident S Pending Investigation			1 Yes 2						
Divisi spital or Att tours after de neral Direct filled in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, street,	factory, office buildin	ig, etc.	or Town, St		Rural Route Number, City		
ospits hours unera ly fille		4 Homicide	(Specify)		d - 4 4 5 - 4 - 5	4 11 12 12 12 1		(-)	4.4		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only one) 2 ✓ Medical Examiner: On	To the best of my knowledg the basis of examination a								
To To con	Med	29b. Signature and title of certifier	d mahner stated.		29c. License num			29d. Date signed (M			
		MILANA	/////		O.C.M.E.			June 14, 2006			
		30. Name and address of person who com	p)eted cause of death (Item	23a)		<u> </u>					
		/	nt Medical Examiner		Street, Baltimor	re, MD 212	201				
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re	40	. 19					
Regist	rar	A 6 200	D. Santage	1	50			. 4			

		1	For State Registrar	State of Ma	ryland		artment rtificate			and M		Reg. No.	06	1958	8
	Physicia /Medic	al		ahl							June June	1, Day 2	2006	3. Time of Dea 11:35P.	
	Examin	er	4a. Facility Name (If not institution, g Montgomery Gene	ive street and number) ral Hospita	1			ney	Location o	of Death			nty of Death	ery	
	Funeral Director		5. Social Security Number 112-07-3908	Sex 7. Age 1 M 2 F 7. Age	(In yrs. las		If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bird (Month, Da March1	2,1918	Cou	Jersey	reign
	anyland ehow	5	Usual Residence of Decedent 10a. State 10b. County Manual Lord Mont com	0777	10c. City,		s Spri	no.						10d. fnside City Li	
	with the M s or 28a-f be notifie	Directo	Maryland Montgom 10e. Street and Number 2127 Edgewater P			TIVEL	10f. Zip		03			10g. Citizen o			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent E	ю		Was Deced If Yes, spec	ent of His			ecify Yes or No Rican, etc.)	- 14. R B	lace - Ameri fack, White cify:		
215-00	ithin 72 house.	Completed	15. Decedent's (Specify only highest of the secondary (0-12)	Education grade completed) College (1-4or 5-	+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done di se retired)	u <i>ring</i> mos	t of worki	ing	16b. Kind of		ations	
Maryland 21215-0036	ibe filed w ntal Hygier ed other th	Be Cor	17. Father's Name (First, Middle, La		2	COMM	xdity		18. Mothe	or's Name Delia	e (First, Middle a	1	-		
	nd 2 should alth and Me 27 is mark r traumatic	To	19a. Informant's Name/Relationship Nancy K. Zappala			19b. Maili 2 1 27	ng Address Edgew	(Street a	nd Number Par	er or Rura kway	Al Route Numb Silver	er, City or Tov	vn, State, Zi g, Mai	cyland 20)903
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Balti	permit. Departi Importa any Inju		21. Signature of Funeral Service Lic	I home-	_ ~	Dc 44	2. Name an onald 400 Fo	V. E	s of Facility SOTSW	årdt 1 Ro	Funera ad Belt	l Home sville	, PA ,Mary	Land 2070)5
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Division of	ath. rr: After	Certification:	27. Manner of Death 1	t be 290 Place of Inju	y Year)	28b. Time o Injury ne, farm, s	М		/ at ⟨? Yes 2 □	No				ral Route Number	,
Ö	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	edical Cert	29a. Certifier 1 Certifying (Check only 2 Medical E	Physicien: To the best of xeminer: On the basis of	of my know f examination	rledge, dea	ith occurred	at the tim	ne, date ar	nd place,	and due to the	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)	
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	(30. Name and address of person w				101 P	rince	e Phi	lip	Dr. Olı	ney, Ma	rylan	d 20832	
All and the	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 6	2006 32. registra	ar's Signatu	A A	perk	<i>p</i>							

Kenneth J. Klebous

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		1- For State Registrar		Cert	ificate o	t Death				F	Reg. No	-	
Physicia edical Exami	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										3. Time of Death 1825 hrs	
		4a. Facility Name (if not institution Carroll Hospital Center		mber)		4b. City, Tov Westm		ocation of	Death		4c. Co Cari	-	eath
				7 A /In usa Ina	at histholous	If Under		If Under	24Hrs 9	Data of B	irth(MM/DD/		. Birthplace (State or
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las		Months	Days	Hours	h Alim		,	Fo	oreian
Director		153-56-3127	1 M 2 F		44 Yr	S.			1	May U	1, 196	, 2	Country) NJ
>.		Usual Residence of Decedent 10a. State 10b. County		10c City T	own or Loca	tion							10d Inside City Limits
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Maryland 28a-f show d at once.	ģ		arroll		Wesu						10g. Citizen	of Minat I	
Mary r 28a ed at	Director	10e. Street and Number 1115 Mint Te	rrace			10f. Zip C		21157	,	ľ	rug. Gilizen	USA	
ith the Me 23a or 23 notified						<u></u>							
th wir	Funeral	11. Marital Status 1 Never Married 2 X N		edent Ever in U.S prces?		as Decedent Yes, specify (0- 14.	White, et	merican Indian, Black, tc.
or it	ᇍ		1 Yes	2 🔀 No	1	Yes 2	T No	coocity:			Sno	ecify:	White
rs afte ural", mine	ð	15. Decedent's Education (Spe	or Dates:			ent's Usual Oc			nd of work	done			ess/Industry
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36 hin 7. than edical	ם		4		(Claims	Dir	recto	r		Ins	suran	ice Co
d wit	등	17. Father's Name (First, Middle	e, Last)			<u> </u>				rst, Middle,	Maiden Sur	name)	
215 be file stal H ked c	Be	William G. Kle	ebous					Ame	lia s	Starz	ynski		
21 buld b d Men s mar	ျ	19a. Informant's Name/Relation			19b. Mailir	ng Address	Street					r Town, S	State, Zip Code)
MD 12 sho th and 127 is umat		Amy Klebous/w	ife			1 Ches							
nore, MD 21215-0036 sizes 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene tr. If teen 27 is marked other than "natural", other traunnatic event, the Medical Examiner		20a Method of Disposition 1 Burial 2 X Cremation	n 3 Removal fr		lace of Dispo ematory or o	sition (Name other place)	of ceme	etery,		ate 5/200		ation - Cit	ty or Town, State
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service			22.	Name and A	dress o	of Facility					
Ö 7 7 7 1 1		Pritts Funeral Home and Chapel, P										., P.	A. 21157
Physician		23a. Part I. Enter the disease, o failure. List only one cause	r complications that c e on each line.	aused the death.	Do not enter	the modern	ymg, s	den as bar	rdiac Gre	spiratory a	rest, shock,	or he art	Approximate Interval Between Onset and
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<u> </u>		or condition resulting in death)	Due to (or as a	consequence of)):								
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8760, tificate be ng physic as the bur	Ş	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes,	outcome of pregn		etal death	3	Ectopic	pregnancy	v		ate of del onth	Day Year
x 68	cia	past 12 months?	4 Pregr	nant at time of dea	adh =	Other (Specif	v)						
Vital Records, P.O. Box 6 hystrian: The law requires that the death cer this certificate has been signed by the attendi I director, page 2 should be detached for use.	Physicia	1 Yes 2 No 9 U	nknown 9 Unkn	own							_ _		
P.O. es that the igned by I		Part II. Other significant cond	itions contributing t	o death but not re	sulting in the	underlying o	ause giv	en in Par	t I			_	te to the cause of death?
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n of Vital Records, ing Physician: The law require After this certificate has been si tuneral director, page 2 should t] ;	27. Manner of Death	28a. Date	of Injury n, Day,Year)	28b. Time o	f Injury 28	c. Injury	at Work?	28	d. Describe	how injury	occurred	
On tendingsath.	ij		nding estigation				1 Y	es 2 1	No				
Division at or Attendirs after death.	<u>;;</u>		uld not be	ce of Injury - At ho	me, farm, str	eet, factory, o	office bu	ilding, etc	. 28	If. Location or Town.		Number o	or Rural Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after dead. After this certi rely filled in by the funeral director	Certification:		ermined (Specify,							OI TOWN,	Olale)		
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	<u>Š</u>	29b. Signature and title of certi	fier /	,				number					(Month, Day, Year)
MST		Califold	024				O.C.N	1.E.			June 1	11, 200	6
1 Par		30. Name and address of person					5		ID 040-				-
20	A	Zabiullah Ali, M.D.	Assistant Medi			enn Street	Baltir	more, M	7ID 2120	JT -			
	state	31 Date filed (Month, Day, Yea	32. R	egyrar's Signatu		book							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? | | | | For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2000 **Physician** 1126 JUNE GRACE JANE KILEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WisoMICO REGIONAL 544188011 MEDICAL PENINSULA renter Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 01-21-1937 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 ☐ M 2 🖾 F 194-26-0437 69 PENNSYLVANIA Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County r than "neturel", or Items 23s or 28s-f ehow the Medical Examiner must be notified at M☐Yes 2 ☐ No WICOMICO SALISBURY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 422 HAMMOND STREET 21804 USA filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give⁴ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify. WHITE δ Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME is marked other permit. Peges 1 end 2 should be file Depetrment of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event SDR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANTHONY SGRO GRACE JOAN LUNA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY KILEY - DAUGHTER 709 E. ISABELLA STREET, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) PARSONS CEMETERY 06-06-2006 SALISBURY, MARYLAND 22. Name and Address of FacilityBOUNDS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. P.m.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DOX **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immadiate cause. Enter Underlying Cause (Disease or injury Examiner physicien end s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RNSiON 1 Yes 2 No 3 Probably Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate 1□ Yes ≥□ No or Attending Physician: After this certification funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Natural 5 Pending М 1 Tes 2 No investigation 2 Accident after death completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

State Registrar 30. Name and add

STEVEN

JUN 0 6 2006

31. Date filed (Month, Day, Year)

100 E CANNOCE ST.

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HAM LETTE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 2006 ROBERT E. LEE JUNE 03 8:10A^M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CALVERT LUSBY 12956 HURON DRIVE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1√2 M 2□ F Director JAN. 23, 1924 WASHINGTON D.C 578_24_0820 Usual Residence of Decedent death with the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Iteme 23s or 28s-f show the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND CALVERT LUSBY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12956 HURON DRIVE 20657 UNITED STATES Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 BUS DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h Pages 1 and 2 should be 1 nent of Heelth and Mentat I int: If frem 27 Is markad o ANNIE ELIZABETH TIPPETT FITZHUGH LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUSBY, MD. RANDY E. LEE (SON) 12956 HURON DRIVE 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny Injury or 2008. 4 Donetion 5 Other (Specify) CEDAR HILL CEMETERY 06-06-06 SUITLAND, MD. 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 21. Signature of Foreyal pervice Licensee 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** AL DISENSE 4RS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner UROSEPSIS use as the burial-transit Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ete has been signed by the ette pege 2 should be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 3No 1 Yes 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ti H0037-228MD JUNE 05,2006 ted cause of death (Item 23a) (Type, Print) 30. Name and address Stephen P. Cafferty, M.D. 225 Town Square Dr. Lusby, MD 20657 31. Date filed (Month, Day, Year) egistrar's Signature State JUN 0 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrat Certificate of Death Rag. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Myrtle Marie Lawrence June 6, 2006 8:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10041 Cape Ann Drive Columbia Howard If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2X)F Director 82 Yrs 378-20-6285 1924 Michigan Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 27 is marked other than "natural", or items 23s or 28e-f shov traumstic event, the Madical Examiner must be notified at 1 Yes 2X No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours effer deeth with to nent of Heatth and Mental Hygiene. ant: if Item 27 ia marked other than "natural", or Items 23a or? 10041 Cape Ann Drive 21046 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Technician Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Wilbur Garvie Vivian Boyce ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Brian Lawrence/son 10041 Cape Ann Dr. Columbia, MD 21046 f Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of F Important: if ite any injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 06/08/06 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 Bluerly 2. Mechante MO1251 Beverly I. Heckrotte, P.A. (23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Adenocarcinoma of Lung 20 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, s been signer Anemia 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has l irector, page 2 s autopsy performed? Yes 2 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ND D30573 June 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10065 Little Patuxent Pkwy. Columbia, MD 21044 Jon K. Minford, M.D. 32. Pigistrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 8 2006 Registrar

			For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment tificate	of He	ealth ar Death	nd Men		gienez Reg. No.	006	195	593
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-	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	* .	If Under		If Under 24 Hours	4 Hrs. 8. C	ate of Bird Month, Da	th y, Year)	9. Bir	thplace (State or ountry)	r Foreign
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lar	ic a de de de de de de de de de de de de de	ToB	John T. McCawley					Loy1	la Jua	nita	Schmi	dt		
Maryland 21215-0036	should Not a manual man	-	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	ng Address	(Street a	nd Number	or Rural Ro	ute Numb	er, City or T	own, State,	Zip Code)	
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Baltimore,	permit. Pages 1 and 2 should be liled within 72 hours atter death with the maryland. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other treumatic avant, If a M-sical Examinar must be nutilied at ange.		20a. Method of Disposition	1 0	lace of Dispo emetery, crer	sition (Nam	ne of ther place)	Date		20c. Loca	tion - City or	Town, State	
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alti	mit. partir porta y inju		21. Signature of Funeral Service Licenses	to home	22	. Name an	d Addres	s of Facility	Brins	field	Fune	ral H	ome PA.	
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18 B	16		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death	n. Do not ent	er the mode	e of dying	, such as c	ardiac or res	spiratory a	rrest,		Approximate Interval Bets	ween
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			30. Name and address of person who cor	polated source of death Pre-	n 22a) /T				-		0	1	I acres	1 +
			Dr. Rakhi Kris				tal F	Point	Look	O11+ F	2d. p	O. Boy	Leonard 527 Mary	
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	اد Regist		JUN 1 2 2006	Bearing Mr.	-	4,								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Violet Ellen Louden June 14 2006 2:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21744 Louden Lane Lexington Park St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F Yrs Director 220-38-2009 100 11-28-1905 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 21744 Louden Lane 20653 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter a Department of Heelth and Mental Hygiene. In term 27 ie marked other then "naturel", or least fillury or other traumate. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 III No Specify: δ If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Own Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Jacob Louden Margaret Pegg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Daniel Simpson/Great Nephew 21685 Cambria Street, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer Cemetery 6-20-2006 Lexington Park, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oaset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tos /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to to as a Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence the attending physicien hed for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outco fe 1 ☐ Live birth of oregnancy 23b. Was decedent pregnant 23d. Date of deliver 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 PNo Records, P.O. 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Division of Vital 1 Yes 2 No Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: the Hospitel or Attending Injury 1 @Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 2 (Type, Print) 30. Name and address of pirs in who completed ca 24035/ Three Notch Road, Hollywood, MD 20636 James P. Jatboe, 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Baptista Lucchesi May 29, 2006 10:52A Guido /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laure1
Year If Under 24 Hrs.
Days Hours Min. Prince George's Laurel Regional Hospital 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral 1** 2 ☐ F Months Days 90 Director 577 38 9878 August 29,1915Washington,D.C. Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ul Hygiene. other then "naturel", or Itame 23a or 28a-f ehow vent, itte Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Prince George's **Beltsville** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3116 Craiglawn Road 20705 **USA** filed within 72 hours after deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 N1942-If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give 1342 Year or Dates: 1945 Baltimore, Maryland 21215-0036 1 ☐ Yes ♣ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Clerk** U.S. Government permit. Pages 1 and 2 should be filed v. Deperment of Health and Mental Hygie. Importent: If Item 27 is marked other tt any injury, or other treumatic event, Ital. 2006. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Caspar Lucchesi Antonita Guliani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14916 Windmill Terrace Silver Spring, Maryland 20905 Frank Lucchesi / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 6/2/2006 Silver Spring, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Sed 11800 New Hampshire Ave Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final **Physician** Septic Shock 1 day disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner 4 days Gram Negative Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ettending physicien and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Acute Renal Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Metastatic Encephalopathy certificate 2 🔼 No 1 Yes 2 No 1 ☐ Yes Division of Vital To the Hoepital or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13/ 06 08 D36974 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Nyanjom, M.D. 10724 Little Patuxent Parkway #200 Columbia, Maryland 21044 31. Date filed (Month, Day, Year) 32. Signature 1 4 2006 Colum Registrar

P.O. Box 68760 Division of Vital Records. Hospital or Attending Physician:

director. Be this Certification: After 24 hours after death.

examiner'

1 Yes 2 → No

4 - Homicide

(Check only one)

29a, Certifier

Medical

State

Registrar

26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28c. Injury al Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Watural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

Hospital: 1 ☐ Inpatient

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28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Michae ary 1: J-Ms

Other:

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Michael Street, 2/// the Mary

31. Date filed (Month, Day, Year) 32 Aegistrar's Signature 2006

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Baltimore,	s 1 ar		20a Mathod of Disposition (200, Flace of Disposit) Harmony Dri ion (Name of tory or other place)	ate 20c.	Location - City or T	own, State
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	within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	, Day, Year)
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,	10th		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	int)		111/00	76
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State of Maryland / Department of Health and Mental Hygiene ? 1 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June **Physician** James Stewart Lloyd 2006 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ctr Carroll Lutheran Village Health Care Westminster
If Under 1 Year | If Under 24 Hrs. Carroll B. Date of Birth (Month, Day, y July 17 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 7°°1916 Days Hours 1 GM 2□ F 212-10-9614 89 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at Director Carroll 1 Yes 2 No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itama 23a by Funerai 300 St. Luke Circle 21158 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1945 1 Styles 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 1946 Specify 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than " Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier Postal Postal other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James E. Lloyd Mary E. Akehurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 Littlestown Pike Westminster, MD 21158 James S. Lloyd, Jr/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 13, 2006. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens * 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD Prince Afuncially Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner to (or as a consequence of) The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
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The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician the To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: if item 27 Is marked othe any injury or other traumatic event, once. **Physician** /Medical Examiner Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature an title of certifier Alkn Philip, MD 120063044 10 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad unns Shock Transa Ctr 22 S. Greene St Buttonine Mb 21201 Allen Phily 32. Progistrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 6 2006 Registrar **ORIGINAL**

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8	ural, c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:							Specia			
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12	withir iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ral Di					Funeral	l Hom	e Owner	r
<u>م</u>	e filed Il Hygi other vant, I	Be C	17. Father's Name (First, Middle, Last)		1				's Name	(First, Middle,	Maiden Sumai			
/lar	should be ind Mental marked o umatic svs	10	Clarence W. Lee					Ma	ry A	 Lough 	ıran			
	2 sho		19a. Informant's Name/Relationship (T)	ype, Print)		semies 2015					er, City or Town			
ത്	1 and 2 Health tem 27 othar tra		Clarence W. Lee,	III.	6633 Place of Dispo cemetery, crea	Old Al	extar of	ndria			L. CLin 20c. Location	COD .	MD 2073 own, State	35
Jor	nt of the street		1 ☑ Burial 2 ☐ Cremation 3 ☐ I		cemetery, cre Olive				June 20		Washing			
Baltimore,	permit. Pages Department of t Important: If Ite any injury or of		21. Signature of Fune and Specify,								al Home			Α.
B	Depar Impo any ir		Michael W. 1	ce	81	25 Sou	the	rn Ma	ryla	nd Blv	d., Owi	ngs,	MD 207	36
	š		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of		th. Do not en	ter the mode	of dying	, such as c	ardiac or	respiratory a	rrest,		Approximate Interval Betw	veen
1	Physician		shock, or heart failure. List only of Immediate Cause (Final ABDOM IM disease or condition resulting in death)	PLAORTIC	ANE	URYS	M						Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or as a conse										
	Examine:	-	Sequentially list conditions,	b. Due to (of as a conse	quence off.									
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
Ć.	ie be executed ysician and e burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):									
		cai		d										
89 >	death certificate t e attending physion of for use as the to	Physician/Medi	IF FEMALE:	00 1/ 1/2										
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1☐Live birth 2☐Fet 4☐Pregnant at time of	al death 3[☐Ectopic preg ☐ Other (spec						ate of deliv onth	-	ear
O.	that the de ed by the detached	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	death J	_ 0.1161 (3,000	Ciry)							
<u>a</u>	The law requires that the ate has been signed by th page 2 should be detache	by Pt	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	inderlying cau	use give	n in Part I.		23e. Did t	obacco use con	tribute to	the cause of de	ath?
rds	w requires been sign should be		INTERSTITAL	LUNG DI	SERSE	<u> </u>				1 🗆 '	Yes 2□No	3 🗆 Pro	bably 4	nknown
Records,	law requas been 2 shoul	Completed	CHRONIC ASPI	RATION						24a. Was	an 24b.	Were aut	opsy findings a	vailable
	The la	Son								perfo 1 ☐ Yes	rmed? 213 No	death?	2□ No	
of Vital	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			Check only		ssist	1,777	ing
o	Phys this ral dii	- To	1 Yes 2 No	I inpatient 2	ER/Outpatie		c. Injury	4 🗆 1401			dence 6 XOt		TV)	nter-
O	Attending in death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	Work	(? Yes 2 □ N			, ,		٠	
Division	at or Attendil after death. t Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reel, factory,	office		2	18f. Location (Street and Num	ber or Rui	al Route Numb	70 <i>f</i> ,
Ö	tospitat or to hours afte unarat Dire	Cert	1 110	Building, 810. (Spec						,				
	To the Hospitat within 24 hours of To the Funarat I completely filled	edical	29a. Certifier 1. Certifying Physics (Check only one) 2 Medical Example one)	ysician: To the best of my kr iiner: On the basis of examin and manner stated.	nowledge, deal nation and/or in	th occurred at nvestigation, in	t the tim in my op	e, date and pinion, death	d place, a h occurre	and due to the	cause(s) and m date and place	anner as and due	stated. to the cause(s)	
	To t Com	Σ	29b. Signature and title of certifier	Cinal 1	40			number	>		29d. Date sign	ed (Month	, Day, Year)	
			* Llyns (NIICEN,	14)		13 C	23.	5		June	1, 2	2006	
D	7+1	Legende	30. Name and address of person who o				r FC	Τ	w1	3- 35	mland O	0754		
	St	ate	Glynis A. Moody, 31. Date filed (Month, Day, Year)	32, Registra Sign	nature			•	ик11	k, Mar	yland 2	0/34		
	Regist		JUN -	6 2006 Asse	w K	Loan	w	0						

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certific	cate of D		Wiemarri		leg No.	200	6 1960
Physicia	ın/	Decedent's Name (First, Middle,Last					2. Date of Dea Month	Day	Year	Time of Death 1030 hrs
edical Exami		Ronald 4a. Facility Name (if not institution, given	Kelvin	I _{4b} (Lee	ocation of Death	June 6, 2		ounty of Death	
		Prince Georges Hospital			heverly	ocalion of Death			ce George	
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last b	irthday) If	Under 1 Year	If Under 24Hrs	s. 8. Date of Bi	rth(MM/DD/		thplace (State or
Director		215-70-8955	M 2 F 49	Yrs.	onths Days	Hours Min	01/1	8/195	Foreig	_{untr} Maryland
		Usual Residence of Decedent			1			0,125		
w any		10a. State 10b. County	10c. City, Tow	n or Location						10d. Inside City Limits 1 X Yes 2 No
-f sho	ţ	Maryland Prince 10e. Street and Number	e George Su	itland						
th the Maryland 23a or 28a-f show any notified at once,	Director				f. Zip Code			-	of What Coul	ntry?
vith th	al	3804 Regency p	kwy Apt 204	13. Was De	2074 ecedent of Hiso	o anic Origin? (Si	pecify Yes or No	USA - 114		ican Indian, Black,
72 bours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	1 X Never Married 2 Married		If Yes,	pecify Cuban,	Mexican, Puerto	Rican, etc.)		White, etc.	, , , , , , , , , , , , , , , , , , , ,
after c	by F	3 Widowed 4 Divorced	If Yes, Give Year 1978-84	1 Ye	2. No	specify		Spe	ecify: Bla	ck
hours matur	edt	15. Decedent's Education (Specify of	nly highest grade completed) 16a			on (Give kind of to NOT use ret		16b. Kind	of Business/	ndustry
36 in 72 in dical J	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)		3 · · · · l · · ·				5 17	dore
5-0036 iled within 72 Hygiene. I other than	팃	17. Father's Name (First, Middle, Last		kille			e (First, Middle,		Bull name)	Jers
MD 21215-0036 A 2 should be filed within 72 hou lith and horial Hylien w north in 17 is marked other than "nat numaric event, the Medical Exa	Be	Perrie Nelson I 19a. Informant's Name/Relationship (ee Sr.			Grace (Cather	ine S	Stewa	rt
D 2121 should be f and Mental 7 is marked	P									rt Zip Code 20746
		Harriett Lee /		3804 F			apt 2		uitlar ation - City or	
5 - S - S - S - S - S - S - S - S - S -				atory or other		, l			•	,
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify 21. Signature of Funeral Service (ce)	Mary	land V	etera:	ns 6/	15/06	[Che]	ltenha	am, MD
Balti permit. Departm Imports injury o		. / / / /	\mathcal{L}_{1}	2060	5 2013	Ada	ams Fu	nera.	HOME	PA N608
Physician		23 Part I Ent, the disease, or com	lication that caused the death. Do ech lie. Cocaine intox	not enter the m	ode of dying, s	uch as cardiac o	or respiratory an	rest, shock,	or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a		ease	оприсае	ed by aut	erosciero	OULC		Death
ĵ.		or condition resulting in death)	Due to (or as a consequence of):							
	Ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):							-
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of):							
ecuted and transit		events resulting in death) Last	sub to (or do d consequence et).							
al al	Medical	X unpended	AMENDED item#23a,PI	I,27,28a-	f,perME,	g856 , 6/22	/06 TT			
760, ficate be ex g physician the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnance		• [7		1	ate of deliver	
Sox 687 leath certific e attending progress to	/sician/	past 12 months?	1 Live birth 4 Pregnant at time of death	2 Fetal of	eath 3 ∟ (Specify)	Ectopic pregna	ancy	Mo	nth [Day Year
Box e death c the atten ed for us	Physi	1 Yes 2 No 9 Unknow	9 Olikilowii							
, P.O. res that the signed by be detach	by P	Part II. Other significant conditions		ting in the unde	rlying cause giv	ven in Part I.				the cause of death?
S, F quires en sign ald be		<u>Diabetes mellitus</u>					24a Was			pably 4 Unknown
cords law requi	ompleted						auto			topsy findings available completion of cause of
tal Rectian: The certificate ector, page	S						1 🗸 Yes		1 🗸 Ye	es 2 No
ician: s certif	Be	25. Was case referred to medical examiner?	Hospital: 1	Outpotiont 2		of Death (Check		Danidana	6 Otto	
of Vital Records, ing Physician: The law require After this certificate has been si uneral director, page 2 should b	٠.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28t	o. Time of Injury			ng Home 5 28d. Describe	Residence how injury of		
On Clending eath or: Aft the fun	ertification:	1 Natural 5 Pending	(Month, Day, Year) Fnd 6/6/2006 unl	k	1 Ye	es 2 No	Unknown			
Division lal or Attendi rs after death at Director: A	ifica	2 Accident Investiga 3 Suicide 6 X Could no	28e Place of Injury - At home		ctory, office bu	ilding, etc.	28f. Location (Street and I	Number or Ru	ral Route Number, City
Div pital or ours afte neral Dir filled in	Cert	4 Homicide determine	(Specify) found in de	welling_			Washingt	on, DC	9 49 1П.	Place, NE
Division of Vital Records, P.O. Box 68' within 24 hours and a fact detail or Brystian: The law requires that the death certiff to the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	(Chock Gray	ian: To the best of my knowledge, or on the basis of examination and/o							
To 1	Med	29b. Signature and title of certifier	and manner stated.		29c. License					nth, Day, Year)
		Ω / Λ	1		O.C.N			June 7		, = +,, . 00//
		30. Name and address of person who	completed cause of death (Item 23a	a)	L			1		
D8 IVA	S 9	7 / 11	puty Chief Medical Examin	er 111 P	enn Street,	Baltimore, N	/ID 21201			
S Regis	tate	31. Date filed (Month, Day, Year) JUN 1 4	32. Rigistrar's Signature	Some	2					
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			For State	State of Marylan	-	artment of H		ental Hy		2006	19602
			Registrar 1. Decedent's Name (First, Middle, La	ct)		Timeate of t		2. Date of De	Reg. No.		3. Time of Death
	Physici	an						Month	Day	Year	13. Time of Dealin
	/Medic	- 1	ROBERT LEONA			1		MAY	28	2006	1336 m
	Examin	er	4a. Facility Name (If not institution, giv		. ,	4b. City, Town, or	r Location of Death		4c. 0	County of Death	
		, k		AL HUSPITA		LA	FOTON			TALBO	7/
	Funeral Director		200-12-4860	Sex 7. Age (In yrs. 82	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month Di FEB 12	1924	9. Birth	place (State or Foreign ntry)
	land w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation					10d. Inside City Limits
	the Maryland 28a-f ehow	5	NC PIT	arm.	GRIFT	COM					X Yes 2 □ No
	28a-	Director	NC PIT	<u> </u>	GRIFI				10- 0%-		-1-0
	Vith to	Ö	roe. Street and Number			10f. Zip Code			rug. Citiz	en of What Cou	ntry?
,	23.	rai	6521 FAIRWAY DR				3530			USA	
11/6/	within 72 hours after death with the Maryland ene. then "natural; or Items 23a or 28a-f show the Madical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 Yes No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or Ne lican, etc.)		4. Race - Ameri Black, White Specify: WE	
m:///	be filed within 72 hours ital Hygiene. Ind other then "natural", event, the Madical Exa	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of workin	g	16b. Kin	d of Business/Ir	ndustry
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an a	od be	Be	RALPH MILLER				HELEN H			,	
Z 1	I Me	5		(Time Delet)	10h 11-					T 01-11 7	- 0-4-1
$\mathcal{C}\mathcal{M} + \mathcal{L}$ Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta importent: if Item 27 is marked eny injury or other traumatic evonce.		19a. Informant's Name/Relationship (ELIZABETH W. MIL	• • • • • • • • • • • • • • • • • • • •			ROAD, FED				
\$ 0	1 an Heal em 2 ther		20a. Method of Disposition			osition (Name of		ate		ation - City or T	
13 P	ges it of or o		1 Burial 2X Cremation 3	Removal from State	cemetery, cre	ematory`or other plac	ce)				
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<u>a</u>	epar por ny in		21. Signature of Funeral Service Lice		Í	2. Name and Addre FELLOWS • I	ss of Facility HELFENBEIN	& NEW	NAM I	UNERAL	HOME PA
ш	20 E = 0		Soseph 71. U	strushi CF.SP.	N	200 S. HAI	RRISON ST	EASTON	, MD	21601	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	h. Do not er	nter the mode of dyin	ng, such as cardiac or	respiratory a	arrest,		Approximate Interval Between
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P.O. Box 68760,	leath certificate be attending physici I for use es the bu	Physician/Medical	IF FEMALE:								
õ	h ce endii	7	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		☐Ectopic pregnancy	,		2	3d. Date of deliv	•
m.	deat e att	Cig	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		Other (specify)	<u>'</u>			Month	Day Year
0	the sche	ys	9 ☐ Unknown	9□ Unknown							
٠	thet ted b	Ē	Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
ds	wrequires thet the death cer been signed by the attendir should be detached for use	d by	None					1 🗆	Yes 2]No 3 ☐ Pro	bably 4 Unknown
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ō	Phys this al dil	P.	1 Yes 2 No	1 Inpatient 2	ER/Outpatie	SIL SU DOA	4 🗆 1401 Sillig 1 1011				fy)
Ē	ing l	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wor		8d. Describe	now injury	occurred	
9.	end eath. or: A	ati	2 Accident investigation				Yes 2 □No				
× ×	r Att	tific	3 Suicide 6 Could not be determined		ome, farm, s	treet, factory, office	2		(Street and		al Route Number,
Ö	i the Hospital or Attending Physician: The I hin 24 hours after death. The Funetel Director: Atter this certificate ha mpletely filled in by the funeral director, page	Certification:		Dansary, etc. (Open)	1/			J., 0, 10	, Olais)		
	spitai nous a inerei C		29a. Certifier Certifying Pl	hysician: To the best of my kno	owledge, dea	ith occurred at the tir	me, date and place, a	nd due to the	cause(s)	and manner as :	stated.
	24 h 24 h s Fui	edical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or i	nvestigation, in my o	pinion, death occurre	d at the time,	date and	place, and due t	to the cause(s)
	o the lithin 2 or the lomplet	₩.	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	signed (Month,	Day Year)

State Registrar

D0056969

30. Name and address of Park VER

31. Date filed (Month, Day, Year)

MAY 3 1 2006 VERTERA MU
32. Registrar's Signature

Sylvia Ann Travis Martin Spills have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of ord distination pre-street and number? Salish have of the salish ha		1 - For State Registrar		State of Ma			nt of H	lealth and			2006	1960
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South Security Number Security Comment Security	Physician /Medical	Sylvia Ann	Travis 1	Martin								10:201
Social Security Numbers C. Sex S	Examiner	4a. Facility Name (If not i	nstitution, give st	treet and number)		4b. Cit	y, Town, o	r Location of De		4c	County of Deat	th
Social Security Numbers C. Sex S	· 20	Salisbur	'y Reh				Sa				Vicor	mico
Total Financiane of December Total Financiane	uneral; irector	5. Social Security Number	6. Sex	20-00		Month			n (Month, D	lav. Yearl	Co	ountry)
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Secretary Secr	ner	11. Marital Status	1	Was Decedent E Armed Forces?	Ever in U.S.	13. Was Dec	cedent of H	lispanic Origin?	(Specify Yes or N	0-		
Henry Kendal Phillips Bertha Marie (unknown)				1 □ Yes 2 🛣 N If Yes, Give	lo				3110 1110411, 010.7			
Henry Kendal Phillips Bertha Marie (unknown)	led	15. [Decedent's Educ	ation	16a.	Decedent's Us	sual Occup	ation		16b. K	ind of Business/	
Henry Kendal Phillips Bertha Marie (unknown)	ple	(Specify on			4)	(Give kind of v life. DO NOT	work done use retire	during most of w d)	vorking			•
Henry Kendal Phillips Bertha Marie (unknown)	Eo	8		oonogo (1 toro	.,	Stock	k Cle	rk		Re	etail St	ore
Henry Kendall Phillips Bertha Marie (unknown) 19b. Mailing Address (Street and Number or Plans Ropes Number City or Town, State Zip Code) 36366 Horsey Church Road, Delmar, Delaware 19940 20b. Method of Desposition 1	Be (17. Father's Name (First,										
Andy Schutz/Friend 36366 Horsey Church Road, Delmar, Delaware 19940 20a. Method of Disposition 1. Separation of Control (Specify) 20b. Place of Disposition (Name at a 20c. Location - City or Town, State and Place) 21. Signature of Defendance Lognor (Specify) 22. Signature of Defendance Lognor (Specify) 23. Signature of Defendance Lognor (Specify) 24. Part Limiter the disease, or conficiencies that sure of the defendance of the Control (Specify) 25. Part Limiter the disease, or conficiencies that sure of the defendance of the Control (Specify) 26. The control of the disease, or conficiencies that sure of the Control (Specify) 27. Signature and Advisors of Family 28. Part Limiter the disease, or conficiencies that sure of the Control (Specify) 28. Sequentially list conditions, any isosofty to certain death. Do not enter the mode of dying, such as cardiac or respiratory arrest, described to the classes of confidence of the Control of the Control of Control of the Control of Co	ပို			_						·	<u></u>	
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Committed Comm			·		- Carlo de		No. of Street,	Church E		-		
Approximate Approximate		1 X Burial 2 ☐ Cre	mation 3 XRe	moval from State	cemete	ry, crematory of	r other plac	· 1				
Approximate Approximate		1	_	00	Oddfello							elaware
Case Part Enter the disease, or conflicitions that Austerd the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infrarral Between Chast and Date of Case (Final deases or crodition) Case of Case (Final deases or Cardino) Case of Case (Final deases or Case (Final deases or Case (Final deases or Case (Final deases or Case (Final deases or Case (Final deases or Case (Final dease) Case (Suc	NOM	und &	136	le	Ze11e1	r Fun	eral Hor	ne, P. O.	Box	3171	MD 21802
Immediate Cause Final deads or condition Cause Cardian Cardi		23. Part1 Enter the dis	sease, or complic	cations that caused	the death. Do						isbury,	Approximate
Sequentially list conditions cause. Enter Underlying Cause. Enter Underlying	n l	Immediate Cause (Final		o cause of each life			p ===	0				Onset and Death
Sequentially list conditions Sequentially list conditions	al		a.	Due to (or as a	a consequence	of):	Col	con 's	100	7		1407
The first properties of the pr		Sequentially list conditio	ns. b.									
The past is a consequence of the past is a	lnei	cause. Enter Underlying	ate 2	Directo (or as)	a nonsequenne	off)r						
FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fefal death 4 Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No 9 Unknown 1 Yes 2 No 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 25b. Was case referred to medical examiner? 25c. Was case referred t	хап	that initiated events	с.	Due to (or as a	a consequence	of):						
IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		1										
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24a. Was an autopsy prior to completion of cause performed? Ves 2 No	\$	Partin Other significant	conditions conf	tributing to death bu	ut not resulting in	n the underlying	g cause giv	en in Part I.				
25. Was case referred to medical examiner? 1	ted							· · · · · · · · · · · · · · · · · · ·	Set See	Yes 2	EMNO 3∐Pr	obably 4 Unknow
25. Was case referred to medical examiner? 1	100								auto	opsy	prior to	topsy findings available completion of cause of
examiner? Sexaminer Sexam												2 □ No
27. Manner of Death 1 Manural 5 Pending investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29e. Certifier (Check will) one) 29a. Certifier (Check will) one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	examiner?		ospital:			l Ott					
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29a. Certifier (Chick with one) 29b. Signature and title of certifier 29b. Signature and decrease of person who completed cause of death (Item 23a) (Type, Print)	Sert	4 D Homicide		building, etc	c. (Specify)				City or 10	own, State	9)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		(Check only 2	Certifying Phys Medical Examin	er. On the basis of	examination an	e, death occurre	ed at the tir on, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s o, date and) and manner as d place, and due	stated. to the cause(s)
William H. Bobins, M.D. 200 Civic Ave, Salisbury, MD 21804	Me	29b. Signature and title of	of certifier /2			2	9c. Licens	e number		29d. Da	te signed (Monti	h, Day, Year)
William H. Bobins, M.D. 200 Civic Ave, Salisbury, MD 21804		100	A-	1/			50 5	2870	P	6	15/1	,
William H. Robins M.D. 200 Civic Ave Salisbury, MD 21804		30. Name and address of	f person who cor	mpleted cause of de	eath (Item 23a)	(Type, Print)		117		/	2/16	
State 31. Date filed (Month, Day, Year) 7 2006 32. Registrar's Signature			HO	lobing	m.D.	200	CIV	ic. Aim	Salis	sbu	CM.W	218c4
	State		y Year 7	Ollh 32. Registra	ar's Signature	Ann	K 1	1 100			J	

			State of Marylar				•	•	10501
			1 = For State Registrar		rtificate of			Reg. No.	19604
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De. Month	ath Day Year	3. Time of Death
	/Medic	al	MARY ANN McCARTHY 4a. Facility Name (If not institution, give street and number)		4h City Town or	r Location of Death	JUNE	14 2006 4c. County of Dea	5:15p M
	Examin	er	107 Boxwood Lane		Galena			Kent	ui
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th 9. Bir	thplace (State or Foreign buntry)
	Director		055-28-4213 70 Usual Residence of Decedent	115.			June 1	L7 1935 No	ew York
	aryland show	_		ty, Town or Lo	cation				10d. Inside City Limits
	the Ma	ecto	MD Kent Ga	alena	10f. Zip Code			10g. Citizen of What Co	1½ Yes 2 No
	3a or	Funeral Director	107 Boxwood Lane		21635	5		U.S.A.	ountry?
	ams 2	iner	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13. V		ispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No		
36	rs afte	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1⊡Yes 2√ No	Specify:	, , , , , ,		Thite
9	be filed within 72 hours after death with the Maryland vial Hygiene. Ind other than "natural", or itams 23a or 28a-f show event, the Medical Examinar must be notified at		15. Decedent's Education	16a. Deced	dent's Usual Occup	ation		16b. Kind of Business	
21	ithin 7 ne. han "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. E	DO NOT use retired	_		Board of	
d 21	e filed w at Hygier other ti vent, Li		17. Father's Name (First, Middle, Last)	Secre	tary -	Tresurer		Superviso	rs
lan	Mental Mental arked c	To Be	John W. Gleason			Ann Bor	an	,	
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship (Type, Print)				Route Number	er, City or Town, State, 2	Zip Code)
	s 1 and 3 if Health item 27 other tra		James McCarthy (husband) 20a. Method of Disposition 20b. F	107_	Boxwood sition (Name of natory or other place	Lane C	alena	MD. 216 20c. Location - City or	
ē	Pages nent of int: if it		X Bullar ,2 Contination 3 Challovarillon State		natory or other plac Cemeter	1	/06	Galena,	
Baltimore,	permit. Pages Department of t important: if its any Injury or o'		21. Signature of uneral Service Licensee	22.	. Name and Addres	ss of Facility			
_	205 2		M00.5	$10 \mid 1$	18 West	Cross S	it. Ga	lena, MD.	L Schaech
	Til matetan		shock, or healt failure. List only one cause on each line.	. 1	^		respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a Due to (or as a conseq		ing Cor	COL			
	Examiner	_	Sequentially list conditions, b.						
3	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	uence ot):					
O O	be executed sicien and burial-transit		that initiated events c	uence of):					
8760,	<u> </u>	dicai	d						
9 xc	The law requires that the death certifica Ite has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnant					23d. Date of del	iverv
Box	death ne atte	siciai	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	hat the d by th		9 ☐ Unknown Part II. Dther significant conditions contributing to death but not res	ulting in the un	adorhing on the state	no in Dort I	230 Did to	bbacco use contribute to	the enuse of death?
Records,	uires tha signed Id be del	d by	Taken. Since significant conditions contributing to death but not less	siting in the dis	idenying cause give	an in Fait i.		_	obably 4 Unknown
000	aw requir s been s 2 should	Completed					24a. Was		topsy findings available
Ä		Com					autop perfor 1 ☐ Yes	rmed? death?	completion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othe	26. Place of Death			
of		n; To	27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury	at 2		lence 6 Other (Spectow injury occurred	cify)
sion	Attending r death. sctor; After	atlo	1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	M 1 1	Yes 2 □ No			
Division	l or Attener after death Director; I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At he building, etc. (Specif.	ome, larm, stre y)	eet, factory, office	2	BI. Location (S City or Tow	Street and Number or Ru m, State)	ral Route Number,
	To the Hospital or Attentwithin 24 hours after dealt To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my kno	wledge, death	occurred at the tim	ne, date and place, ar	nd due to the o	cause(s) and manner as	stated.
	To the Ho within 24 h	ledical	(Check only 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my op	pinion, death occurre	d at the time, o	date and place, and due	to the cause(s)
	with To	Σ	29b. Signature and the pl certifier		29c. License			29d. Date signed (Mont)	
•			30. Name and address of person who completed cause of death (Iten	1 23a) (Type I		060301		6/15/	00
_	c/		Michael C. Peimer, MD.	122 S		. Cheste	rtown	, MD. 216	20
Ì	Sta		31. Date filed (Month, Day, Year) 32 (Spistrar's Signal JUN 2 1 2006	lang the land					
	Registr	ar	JOIN & T COOL TO STATES Y	- 17	Con				

			For State	State of Ma	arylan				Mental Hy	giene2	006	19605
			Registrar			Ce	rtificate of	Death	1	Reg. No.		
	Physicia	an	1. Decedent's Name (First, Middle, L			_			2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	DOROTHY LOUIS		ISEL		# 0: T		June	01	2006	12:10A M
	Examin	er	4a. Facility Name (If not institution, g			nter		Location of Death	1		unty of Death	.3.1
			Crofton Conval 5, Social Security Number 6.			last birthday)	Crofto:	If Under 24 Hrs.	8. Date of Birth		ne Arui	
	Funeral Director		578.46.7317	1 □ M 212 E	93	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Feb. 11	, Year) , 191	3 Pied	place (State or Foreign ntry) mont, WV
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or L	ocation					10d. Inside City Limits
	Mary	ŏ	Maryland Anne A	rundel	G	ambri1	10					1⊠Yes 2□No
	1 the	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
	h with	Q is	1260 Defense Hig	hway			21054			U.S.	Α.	
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14.	Race - Ameri	
9	after or ite	II.	1 Never Married 2 Married		No		1 ☐ Yes 2 ☒ No	Specify:	nican, etc.)		Black, White, ecity: Whit	
93	72 hours after death with the Maryland natural; or iteme 23e or 28e-f ehow disal Examiner must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:						J.	BCIIY. WIII	.e
5	"nati	iete	15. Decedent's (Specify only highest of	Education trade completed)		(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wor	king	16b. Kind o	of Business/In	dustry
21215-0036	withir lene. than	Completed	Elementary/Secondary (0-12)	College (1-4ors 3 Years	i+)		gistered N	•		Healt	hcare	Services
<u>d</u>	Hygl other	0	17. Father's Name (First, Middle, La					18. Mother's Nam	ne (First, Middle,	Maiden Sur	mame)	
Maryland	Aenta Aenta rked tic ev	To B	Jesse Mullan					Annie	Langhar	n		
ary	and N ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ing Address (Street	and Number or Ru	ral Route Numbe	r, City or To	wn, State, Zij	Code)
Σ	and and a salth		Mary I. Hentgen	/Daughter			Stonybro			Mary1	and 20	715
ore	2 = = = P		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	☐Removal from State	20b. P	face of Disp emetery, cre	osition (Name of ematory or other place	(e)	Date		ion - City or T	
Ë	A = 1 = X		4 □ Donation 5 □ Other (Spec		Ft.	Linco	1n Cremat	tory 06/00	5/2006	Brent	wood,	Maryland
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental hygiens. Incorporate if I tem 27 is marked other than "natural, or iteme 23a or 28a-f show important: if I tem 27 is marked other than "natural, or iteme 23a or 28a-f show eny inJury or other treumatic event, the Medical Examples must be notified at once.		21. Signature of Funeral Service Lic	Samell		2 F 1	2. Name and Addre HINES-RINA 1800 New	ALDI FUNE Hampshir	RAL HOMI	E, INC Silver	Sprin	g,MD 20904
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused to one cause on each li	the death							Approximate Interval Between
	Physician	8 1	Immediate Cause (Final disease or condition	CARDIAC		YTHMIA						Onset and Death
	/Medical		resulting in death)	Due to (or as								
	Examiner		Sequentially list conditions.	FAILURE b.								
	ted nsit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequ	uence of):						
	and I-tran	Examiner	that initiated events resulting in death) Last	c. DEMENT] Due to (or as		uence of):						
8760,	death certificate be executed e attending physicien and d for use as the burial-transit	icai E		200 (0 (0) 03	a conseq.	u 61106 017.					- 4	4
687	phys s the	dic		d								
Box (eath certific attending pl	₹ N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	incy				23d	. Date of deliv	arv
B	death a atter d for u	ciar	in the past 12 months?	1 □Live birth 4 □ Pregnant al			□Ectopic pregnancy □ Other (specify) _	<u>'</u>		200.	Month	Day Year
P.O.		Physician/Med	9 Unknown	9□ Unknown								
	res the igned be det	by P	Part II. Other significant conditions	contributing to death b	ut not res	ulting in the o	underlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
ecords,	w requires thet the been signed by th should be detache	ed							101	′es 2□N	lo 3 Prol	oably 4 Dunknown
ec.	aw r	Completed							24a. Was		4b. Were auto	opsy findings available impletion of cause of
α	± ee e	O.							perfor	m ed?	death?	
Vital	ician: Th certificate rector, peg	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	ne)		
of \	this al di	ဥ	1 ☐ Yes 2 ☼ No			ER/Outpatie		4 Ky Nursing n	ome 5 Resid			5)
Ž.	fer far	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	Wor		28d. Describe h	iow injury oc	curred	
Division	death ctor:	icat	2 Accident investigat 3 Suicide 6 Could not	be /00 01	urv - At he	ome form of	M 1 [Yes 2 □ No	28f Location /	Street and M	umber or P	al Route Number.
Div	To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide determine	building, et	c. (Specify	y)	radory, onice		City or Tow	m, State)	or or nul	
-	spits hours ineral / fillec		29a. Certifier 1 ☐ Certifying	Physician: To the best	of my kno	wiedge, dea	th occurred at the tir	ne, date and place	, and due to the	cause(s) and	d manner as s	stated.
	he Hc in 24 he Fu pletely	Medicai	(Check only 2 Medical Ex	and manner st	f examina	ition and/or in	nvestigation, in my o	pinion, death occu	rred at the time,	date and pla	ice, and due t	o the cause(s)
	To t To t	Σ	29b. Signature and title of certified	1			29c. Licens	e number		29d. Date si	gned (Month,	Day, Year)
	17						D5	7028	3	α	000	2106
	1		30. Name and address of person wh	completed cause of		n 23a) (Type		#121	Planol	TATES	ma	2/00

Registrar
DHMH 17 Rev 1/2001

State

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			For State Registrar		State of I	Marylan	•	artment <i>tificate</i>			and M	-	giene Reg. No.	2006	19	606
	Physici /Medic		1. Decedent's Name (First, Mary C	Middle, Last) ather		lyers						2. Date of De June 7		2006 Year		e of Death 40 P M
	Examin		4a. Facility Name (If not insti Westminster				enter		tmin	ster				County of De		
	Funeral Director		5. Social Security Number 215-26-9137		7.]M 2 X]F		last birthday) 76 Yrs.	Months Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 6,	th (193	9. Bi	rthplace (Sta Country) arylan	te or Foreign d
	Maryland f show	or	Usual Residence of Decede 10a. State 10b. Co		1		y, Town or Lo			-						e City Limits
	with the Page or 286-	I Director	10e. Street and Number 221 Main	St.				10f. Zip	Code	2177	76		10g. Citi	izen of What C	•	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23a or 28a-5 show any njury or other treumatic event, the Midfell Examinant in must be multilised at ance.	Completed by Funeral	11. Marital Status 1 Never Married 2 2 3 Widowed 4 Divo	Married	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	s? █ No		Was Deceded of Yes, special □ Yes 2				ecify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh Specify:		٦,
21215-0036	d within 72 ho giene. or then "netu	completed	15. Dec (Specify only f Elementary/Secondary (0- 8			or 5+)	(Give lite.	tent's Usual kind of wor DO NOT us amstr	k done di e retired)	urina mosi	t of worki	ing		othing	,	ry
Maryland	ould be file Mental Hy arked othe	To Be (17. Father's Name (First, Mi Walter Lee	Fogle						5	Stell	(First, Middle la Grac	e Un	known		
	l and 2 sh tealth and m 27 ls m her treum						P.0.	Box 1	48		w Wi		MD 2	21776		
Baltimore,	t. Pages 1 rtment of H rtent: If iter njury or oth		1 ☐ Burial 2 ☐ Crema 1 ☐ Donation 5 ☐ Oth	Luther A. Myers - husband P.O. Box 148 New Windsor, MD 21776 a. Method of Disposition 1 Burial 2 **Cremation 3 Belmoval from State 4 Donation 5 Other (Specify) All County Cremation June 9, 2006 Sykesville, MD												
, (24)									urch		Nev	rtzler V Winds	or,		16	
	Physician /Medical		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	Ee, or complication of the control o	ne cause on eac	sed the death h line.	ie	He o	J L	, such as	cardiac o	r respiratory a	rest,	<u></u>		mate Between and Death
8760,	eath certificate be executed as attending physician and for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								500	se			Men	ti,	
O. Box 6	00	Physician/Med	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	11(3c. If yes, outcon 1⊟Live birth 4⊟Pregnan 9⊟ Unknowi	n 2 ☐ Feta t at time of d	Ideath 3[Ectopic pre Other (spe					ē	23d. Date of de Month	elivery Day	Year
rds, P	 requires that the been signed by th should be detache 	ed by PI	Part II. Other significant co	nditions co	ntributing to deat	h but not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did t		ise contribute √No 3 ☐ F		of death?
Il Records,	The law ate has b page 2 sl	Completed by										24a. Was auto perfo 1 Yes		prior to death?	completion	ngs available of cause of
of Vital	Physiclen: The this certificate ral director, pag	To Be	25. Was case referred to me examiner? 1 Yes 2 No	-	Hospital: 1 ☐ Inp		ER/Outpatier		Othe	r Nu	rsing Ho	n <i>(Check only o</i> me 5 ☐ Resi	dence (ecify)	
Division o	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	2 Accident in	ending vestigation ould not be etermined	28a. Date of l (Month,	Injury - At ho	28b. Time of Injury	М		at ? ′es 2 □ l	No	28d. Describe	Street an	d Number or F	Rural Route N	Number,
۵	ospitel or hours afte inerel Dir y filled in		29a. Certifier 1 Cer	tifying Phy	sician: To the be	etc. (Specif	wledge, deatl	occurred a	it the time	e, date an	d place, a	City or Ton	cause(s)	and manner a	s stated.	
	To the Howithin 24 To the Fu	Medical	29b. Signature and title of c		ner: On the basi and manner	s or examina stated.	tion and/or in		License		th occurr	ed at the time,		e signed (Mon		
	WIL		30. Name and address of pe	- y	C M	O of death (Item	п 23а) (Туре,	Print)	955	80	37		(01810	9	1700-191
10	Sta	ite	31. Date filed (Month, Day,		32. Reg	forer signa		+ 3	07	W	PSto	ninster	- 1	10 21	157	
	Regist	ar	JUI	V 1 3	2006	leve	J.	freel	1							

			For State Registrar	State of I	Maryland		artment of H		Mental Hygie	ene2 0 0 8	19607
*		- 7	Decedent's Name (First, Middle, L.)	.ast)					2. Date of Death	_	3. Time of Death
	Physici /Medic		HAROLD	THOMAS	MCCA	ABE			MAY 30	, 2006	
	Examin		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City, Town, or	Location of Deat	n	4c. County of De	ath
			FREDERICK MEM	ORIAL HO	SPITA	L	FREDERI			FREDERI	CK
	Funeral Director		5. Social Security Number 6. 216-72-1569	Sex 7. 1 M 2 ☐ F	Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	1957 9. 8	irthplace (State or Foreign DC
			Usual Residence of Decedent						riay 20,	1757	DC
	how		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Ma Fe-f-	cto	MD Fred	erick		Fred	lerick				1 ☐ Yes 2√XNo
	or 28	Director	10e. Street and Number				10f. Zip Code		10g	. Citizen of What 0	Country?
	23°	62	5800 Genesis	Lane			217	701		United	States
	tems	Funeral	11. Marital Status	12. Was Decede Armed Force	es?		Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	
36	ours atter death with the Marylan elf, or items 23e or 28s-f ehow Examiner mast be notified	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Oivorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
8	n 72 hours atter death with the Maryland "naturel", or items 23e or 28s-f ehow idical Extrininations to notified at		15. Decedent's		15.	16a. Dece	dent's Usual Occupa	ition	16	b. Kind of Busines	
15	n "n	plet	(Specify only highest of		king	D. 111112 01 2001100	a mad stry				
21215-0036	illed within I Hygiene. other then "	Completed	Elementary/Secondary (0-12)	C	Carroll C	County Times					
	be filed ital Hygie d other event, II	Bec	17. Father's Name (First, Middle, La.	st)				18. Mother's Nar	ne (First, Middle, Ma	iden Sumame)	
Maryland	ges 1 and 2 should be filed within 72 ho to f Heath and Mental Hygiene. If item 27 is marked other than "natur or other treumatic event, the Midical	To	Harold Thoma	Louise Ha	11						
lar	2 sho and is m		19a. Informant's Name/Relationship						rai Route Number, C	-	
	of Health item 27 other tr		Pamela McCabe 20a. Method of Disposition	POA	20h DI		S Cherokee	Drive	Westminst		21157
Ö	Pages nent of hant of hant of hant of hant of hant if ite		1 ☐ Burial 2 🖎 remation 3		Ce	metery, crer	natory or other place	e) town T		c. Location - City o	
Baltimore,	rtmer rtent rient	4 Donation 5 Other (Specify) South Carroll Crematory June								o winii	era, MD
Ba	permit. Pages Department of Importent: If i eny Injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Cremator 1212 W. Old Liberty Road Winfield.								
			23a Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
	Physician		Immediate Cause (Final disease or condition	a. H	contor	renal	Syna	rome			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):					
* E	2. · š.	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ience of):					
	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events								
oʻ	an an rial-tr	Exa	resulting in death) Last	Due to (or	as a consequ	ience of):					
8760,	cate be executed physician and the burial-transit	dical	1	d							
9	ing pl	0	IF FEMALE:								
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3	Ectopic pregnancy			23d. Date of d	elivery Day Year
	es that the death certific igned by the attending p be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□Unknow	t at time of de n	eath 5∟	Other (specify)				54,
P.0	that the ed by detac	'Ph	Part II. Other significant conditions	contributing to deat	h but not resu	Iting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
Records,	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	d by	Alcohal		hos,				1 ☐ Yes	2□No 3⊡	robably 4 Unknown
Ö	w requires is been si	lete							24a. Was an	24b. Were a	autoosy findings available
Re	elclen: The law s certificate has t irector, page 2 s	Completed							autopsy performe	d? death?	autopsy findings available completion of cause of
Vital		0	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes 20 ath (Check only/one)	No 1 □ Ye	s 20 No
Y	Physician: r this certificated frail director, i	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inp	atient 2 🗆 8	ER/Outpatien	it 3 DOA Othe	-	ome 5 Residence	e 6 □Other (Sp	ecify)
u of	ding Phys	:uc	27. Manner of Death 1 □Matural 5 □ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of	28c. Injury Work	at	28d. Describe how		
Si	Attending or death. ector: After by the fune	atle	Accident investigat	ion				′es 2□No			
Division	or Att fter d Sirect in by	ŧ	3 ☐ Suicide 6 ☐ Could not determine	d 200. Place of	Injury - At hor, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
	pital ours a oral E	Ce	29a. Certifier 12 Certifying	Physician: To the be	ant of multi-	ulodos de l'					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	one)	aminer: On the basi and manner	is of examinati	ion and/or in	vestigation, in my op	e, date and place vinion, death occu	rred at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)
	To To	Σ	29b. Signature and the of certifier	(An . 4			29c. License			Date signed (Mor	
•	WSV		//					57796		114/ 3	0,2006
	10		30. Nambered address of person who Lalit Verma,					Frede	rick, mb	21701	
	Sta Regista		31. Date filed (Month, Day, Year) JUN 07	2006 32. 8	istrar's Signat	b A	7th St.		,		

			1 - For State Registrar	State of M	/larylan			f Health and of Death		jiene jeg. No.	006	19608
	Physici /Medic		1. Decedent's Name (First, Middle, MERLE	Last)	MC	GINN	115		2. Date of Dea Month JUNE	Day 0.4	Zon	3. Time of Death
	Examin		4a. Facility Name (If not institution, g	Assisted		ing	_	n, or Location of Dea			ounty of Death	rundel
Y	Funeral Director		5. Social Security Number 469-40-9046 Usual Residence of Decedent	. Say 1 M 2 ☐ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 You Month's Da		n. (Month, Day	; Year)	9. Birth Con 1 9 2 2	nplace (State or Foreign untry) MN
	show	o.	10a. State 10b. County	-	10c. City	, Town or Lo						10d. tnside City Limits 1 ☐ Yes 2X No
	with the M a or 28a-f be notified	Directo	MD Montgo 10e. Street and Number	•			10f. Zip Cod				n of What Co	
36	s 1 end 2 should be filed within 72 hours after deeth with the Maryland Health and Mental Hygiene. Itsm 27 is marked other than "natural", or itsms 23s or 28s-f show other traumatic event, the Medical Examinar must be motified at	by Funeral Director	4113 Decatur Av 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Deceder Armed Force	s? ∑No	'	Was Decedent	0895 of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes or No- erto Rican, etc.)	14	USA Race - Amer Black, White	
21215-0036	within 72 hou iene. 'then "neturs 're Medicel E	Completed I	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		(Give life.	dent's Usual Oc kind of work do DO NOT use re airdres	one during most of w tired)	rorking		of Business/I	
	ould be filed Mental Hygi arked other atlc svant, I	To Be Co	17. Father's Name (First, Middle, La Merrill Lynn	McGinnis		11	arrures		ame (First, Middle,			V
Maryland	nd 2 should lith and Men 27 is marke r trsumatic	Ė	19a. Informant's Name/Relationship Sandra D. Stand	(Type, Print)				et, Lothia	Rural Route Numbe	r, City or T		
Baltimore,	Page nent o ent: If ury or		20a. Method of Disposition 1 ☐ Bunal 2 🖫 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	□Removal from Stancify)	20b. P	tace of Disponentery, crementary, crementery	sition (Name on natory or other Ltan Cr	place) ematory 0	Date	20c. Loca	tion-City or	
Bal	Depertition of the control of the co		21. Signature of Funeral Service to	R. 6	ren_	R	ausch F	dress of Facility uneral Ho			ngs, M	
· ·	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or coshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Indextyin.	aDue to (or b	as a consequal as a consequal	Fat uence of):		oying, such as cardi				Approximate Interval Between Onset and Death
68760,	eath certificate be executed ettending physicien end for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	uence of):						
P.O. Box	b 6 6	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3	Ectopic pregn Other (specif			236	d. Date of deli Month	very Day Year
	w requires that the been signed by t should be detach	þ	Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	nderlying cause	given in Part I.	23e. Did to			the cause of death?
al Records,	: The law receive hes been page 2 sho	Completed							24a. Was a autop: perfor 1 Yes	Sy	prior to death?	topsy findings available completion of cause of 2 No
of Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 _ tnpa	atient 2	ER/Outpatier	nt 3 DOA	Othor	eath (Check only or Home 5 Resid		Other (Spec	MAZE
Division o	or Attanding after death. Diractor: After in by the fune	Medical Certification:	27. Magner of Death 1 Naturat 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion	Day Year)	28b. Time o Injury		njury at Work? 1 Yes 2 No	28d. Describe h	treet and I		ral Route Number,
	Hospitel 24 hours a Funeral etely filled	dical C	29a. Certifier (Check only 2 Medical E.	Physician: To the be raminer: On the basis and manner	of examinal	wledge, deat tion and/or in	h occurred at the	e time, date and pla ny opinion, death oc	ce, and due to the c curred at the time, c	ause(s) ar late and pl	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1 Heni	ta ur)	29c. Lie	ense number	438	9d. Date :	signed (Month	Day, Year)
	ID		30. Name and address of personal	no composed cause of	-m,	441	Print) DEFE	D 21	JAY ANO	VAPOL	1 MO	21401
2 3	Sta Regist		31. Date filed (Month, Day, Year)	- 6 2006	strafs Signa	ture &	Spark	ا				

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	Physici /Medic Examir	al	1 - State Registrar 1. Decedent's Name (First, Midde ANN TORP 4a. Facility Name (If not institution)	lle, Last) EY MC	NTAG	UE							Reg. No. Death	Count	2006 by of Death	
	Funeral		7903 RADCLIFFE 5. Social Security Number	6. Sex			s. last birthday) If Unde	er 1 Year		r 24 Hrs.	8. Date of B	lirth		9. Birth	pla
	Director		202-28-9160 Usual Residence of Decedent	101	vl 2[XF	/	71 Yrs.	Months	Days	Hours	Will.	8. Date of E (Month, I 11/20	71934	-	C08	
	a-f ehow	ctor	10a. State 10b. Count MD KE			10c. (City, Town or L									100
	th with the 23a or 28	Funeral Director	10e. Street and Number 7903 RADCLIFFE	ROAI)			10f. Z	ip Code 216	20			10g. Citi	zen of US	What Cou	ntr
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel", or items 23a or 28a-f ehow other traumatic event, the Medical Eventies must be rediffed at	þ	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried	Armed F	2 📉 No	U.S. 13.	Was Dec	77	ispanic Oi an, Mexica Specify		ecify Yes or N Rican, etc.)		14. Race - American In Black, White, etc. Specify: WHIT		
5-0	n "natur	eted	15. Decede (Specify only high	nt's Educa	ition completed,)	(Giv	edent's Usi	ork done	durina mo	st of work	ing	16b. Kii	16b. Kind of Business/Industry		
121	within liene.	Completed	Elementary/Secondary (0-12)		College 2	(1-4or 5+)		DO NOT HOMEM							N HOME	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Ie marked other then aumatic event, me M	To Be C	17. Father's Name (First, Middle RAYMOND TORPEY		Z H							ne (First, Middle, Maiden Sumame) HERIDAN				
Mary	and 2 shores and N and N n 27 le ma		19a. Informant's Name/Relation JAMES MONTAGUE			•				al Route Num						
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I eny Injury or other tra BDG&:			ation 3 Removal from State cemetery, crematory or other place) CHESAPEAKE CREMATORY O6/09/2006								- City or T				
Balti	permit. Pages Department of Importent: If It eny Injury or on		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNE 130 SPEER ROAD, CHESTERTOWN, MD 216										FUNER/	 []		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												2	
8760,		I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c.		o (or as a conso										_
.O. Box 687	death certificate e ettending phy: id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	23d	1 Live	utcome of preg birth 2 Fe gnant at time of nown	etal death 3	□Ectopic □ Other (s		,					ate of deliv	er (
Δ.	quires that n signed by uld be deta	þ	Part II. Other significant condi	ions contr	ibuting to	death but not re	esulting in the	underlying	cause giv	en in Part	1.		tobacco u	ise cor	ntribute to t	
I Records,	. The law requires that the sete has been signed by the page 2 should be detache	Completed										24a. We aut per	opsy formed?	24b.	Were autoprior to codeath?	op: om
of Vital	sician: certific rector,	Be	25. Was case referred to medic examiner?		spital:	11			Oth	or		(Check only	r one)			
on of	iding Phys th. : After this i funeral di	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc		28a. Date		28b. Time Injury		28c. Injun Worl	4 🗆 🛚 🔻		me 5 Re 28d. Describe	sidence 6 a how injury			<i>(y)</i>
Division	el or Attending F s atter death. Il Director: After id in by the funera	ertification:	3 ☐ Suicide 6 ☐ Coul	-	28e. Plac build	e of Injury - At ding, etc. (Spe	home, farm, s					28f. Location City or T	(Street and own, State)		ber or Rur	a/

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELEN NOBLE MD 122 SPEER

1% Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0041587

State of Maryland / Department of Health and Mental Hygiene 2	0	1		(
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			FOF	partment of Health and I ertificate of Death	Mental Hygie		19610								
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death								
	Physicia		Raymond C. Miller		06/03/2	006	11:13 a ^M								
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death									
all a	Examin	ei	Southern Maryland Hospital	Clinton		Prince G	eorge's								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	lf Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign								
	Director		579-34-6438 15KM 20F 78 Yrs	Months Days Hours Min.	(Month, Day, Y		th Carolir								
7			Usual Residence of Decedent		10170771	920 1500	CII CalUIII								
	M M		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits								
3	Mar -	to	MD Prince George's Clint	on			1 Yes 2 No								
4	7.28 r 28	irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?								
4	33a o	a D	9211 Stuart Lane	20735	U	.S.A.									
1		Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ameri Black, White									
9	or its	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 √ No Specify:	o i iloan, etc.)										
3	Sing Sing	1 by	3€ Widowed 4 Divorced 1 94 7 Dates 50	TEL TOS ZEMITO SPOCITY.		Specify: Bla	ack								
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, i		du	Elementary/Secondary (0-12) College (1-4or 5+) Sum	e. DO NOT use retired) Prvisor	D	efence D	epartment								
7	t, Ett	S	12												
	d al H	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma										
2	z should be liled within 7.2 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or items 23a or 28e-f show eumatic event, the Modical Examinar must be notified at	၉	Raymond Foster Miller	Mary		Cain									
<u> </u>	is m		A CANADA CAN	ailing Address <i>(Street and Number or Ru</i> 1.1 Mandan Pd (· ·								
2	and eelth m 27 her tr			11 Mandan Rd., (-										
5	OT H		20a. Method of Disposition 20b. Place of Disposition 3 □Removal from State	sposition (Name of rematory or other place)		c. Location - City or T									
	rages ment of i ent: If its ury or o		4 □Donation 5 □Other (Specify) MD Veto			Cheltenha									
	permit. Pages 1 and 2 should be lied within 12 hours after death with the maryia important of Heelth and Mental Hygiene. Important if them 27 is marked other then "naturel", or items 23a or 28e-f ehov eny injury or other treumatic event, the Modical Examinar must be notified at once.		21. Signature o Funeral Service Licensee M 01426	22. Name and Address of Facility Ronald Taylor II 10583 Middleport	Funeral Ln.Whit	l Chapel te Plains	s, MD								
			3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
P	hysician		mmediate Cause (Final lisease or condition a CORONARY ARTERY DISEASE												
	/Medical		ease or condition ulting in death) a. CORONACY AZIE/ZY DISCASIZ Due to (or as a consequence of):												
E	Examiner	,	END STAGE RENAL DISEASE												
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	ansit	Examin	Cause (Disease or injury that infliated events	JSION											
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	ysici	dicai	6 DIA BETES	MELLITUS											
0	as th	led													
5	endir ruse	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	•								
	ne att	sicie	1 Yes 2 No	5 Other (specify)		Month	Day Year								
2	by the	Å,	9 ☐ Unknown												
,	an de de	by	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobac	cco use contribute to t	he cause of death?								
Sp io	en siç	ed	RESPIRATO	CY HAWRE	1 🗆 Yes	2 No 3 Pro	bably 4 Minknown								
2	s be	piet			24a. Was an	24b. Were auto	ppsy findings available								
ř	te ha	Completed			autopsy performe 1 ☐ Yes 2	d? death? (No 1 ☐ Yes	empletion of cause of								
9	tifica tor, p	0	25. Was case referred to medical	26. Place of Dea	th (Check only one)	10 103									
> :	ysich s cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpa	Othor		e 6 ☐Other (Speci	6)								
5	er th		27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at	28d. Describe how										
5	ath.	atio	1 反 Natural 5 □ Pending (Month, Day Year) Injui 2 □ Accident investigation	M 1 Yes 2 No											
INISIOI	ar deg	ific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Run	al Route Number,								
5	s efte	Certification:	building, etc. (Specify)		City of Town, S	nate/									
	To the Hospital of Attending Prysician: The law requires thet the death certilicate be executed within 24 hours eiter death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai (29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, dependence on the desired of the desired	eath occurred at the time, date and place investigation, in my opinion, death occu	and due to the causered at the time, date	se(s) and manner as s and place, and due t	stated, the cause(s)								
	omply omply	Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month,	Day, Year)								
,	- s - 0		I marie so m	DATITE	ת	INF Q	100 G								
	(30. Name and address of person who completed cause of death (Item 23a) (Ty	De Print)		INE 3	2002								
1	7511		SISOM OSIA, M.D. 6192 OXON H	and the same	ON HILL	MD 20	145								
	Sta	te	31. Date filed (Month, Day, Year) 32. Projectrar's Signature	1 11	01. 17700	140									
	Registr		31. Date filed (Month, Day, Year) 32. Rigistrar's Signature JUN 0 7 2006	Goodes!											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2006 Gillespie Susanna McCoy 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 445 Rowland Road Port Deposit Cecil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec. 19 Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F 214-24-3477 77 Yrs Director 1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show wat be notified at Director Maryland 1 Yes 2 No Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 445 Rowland Road 21904 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "na any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Holiday Cross Margaret Kirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ulysses G. McCoy (Husband) 445 Rowland Road, Port Deposit, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 06/07/06 Hopewell Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Port Deposit, Maryland 21. Sign here of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician doKirsons disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a noneequance of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed emelia resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 01h IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No by the 9□ Unknown 9 Unknown s been signed b should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes 2 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manger of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar E Ccc.1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D

6 2006

312

32. Registrar's Signature

Sachder

31. Date filed (Month, Day, Year)

JUN

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NORTH EAST

Funeral Director

T A B	ner	Medical Certification: To Be Completed by Dhysician/Medical Examiner	ш
permit. Pages 1 and 2 should be Department of Health and Mental Importent: if Item 27 is marked o any injury or other treumette even once.	Physician /Medical Examiner	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit	
Baltimore, Marylan		Division of Vital Records, P.O. Box 68760,	- 1

ian ical	1. Decedent's Nam	1071		ORG					-	2. Date Mon MAY		30 2	Year 006	3. Time of 6:22		
	4a. Facility Name (9		own, or Lo	ocation of Dea	ith		4c. County	of Death TAL			
	5. Social Security I	Number	6. Sex	2□ F	7. Age (In	yrs. last birthday) 31 Yrs.	If Under 1	Year If	f Under 24 Hr. Hours Mir		of Birth	924	9. Birtho	place (State or ntry) YORK		
- J	Usual Residence of	f Decedent	,		100	: City, Town or Le	ncation							10d. Inside Cit		
ţō	MD		BOT				MICHAE	ILS						1 🗌 Yes		
Director	10e. Street and Nu	mber					10f. Zip (Code			109	g. Citizen of W	/hat Cou	ntry?		
	24345 W.	DGEON	PLACE	#29				21663	3				USA			
by Funeral	11. Marital Status1 ☐ Never Mar3 ☐ Widowed	_	rned	Armed F	2 No		Was Decede If Yes, speci 1 Yes	fy Cuban, I	anic Origin? (Mexican, Pue Specify:	Specify Yes no Rican, et	or No-		k, White,	can Indian, etc. HITE		
	(Sne	15. Deceder			1	16a. Dece	dent's Usual	Occupatio	on ing most of w	nrkina	10	16b. Kind of Business/Industry				
Complete	Elementary/Sec		ssi grade co	College ((1-4or 5+)	`life.	DO NOT use		ing most or w	Jinniy		WRITER/NOVELS				
Ö	12 17. Father's Name	(First, Middle	. Last)	4		NOV	18. Mother's Name (First, Middle, Maiden Surmame)									
o Be	EMANUE									LEVENS		,				
To Be Completed							ng Address	(Street and	Number or F	Rural Route	Number,	mber, City or Town, State, Zip Code				
	CYNTHIA	PAALBO	RG/WI	FE					PLACE	#29,	ST.	MICHAE	LS,	MD 216		
	20a. Method of Dis	position Cremation	3 □Rem	oval from		Ob. Place of Dispo cemetery, cre			1	Date	20	oc. Location ·	City or To	own, State		
	` 4 □ Donation				10	CHESAPEA				6/1/2	006	STEVE	NSVI	LLE, M		
	21. Signature of F	unerai Service		swsk.	C.F.	. 1179	ELLOWS	, HE	LFENBE	IN & N	EWNA	M FUNE	RAL 1	HOME PA		
cai Examiner	Sequentially list conditions, dary, backed to amendate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease Due to for as a consequence of: C. Due to (or as a consequence of):												26.3			
Physician/Medi	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months?	23c.	1 Live	utcome of pr birth 2 nant at time nown	Fetal death 3	∃Ectopic pre ∃ Other (spe				23d. Date of delivery Month Day					
eted by P	Part II. Other sign	ificant condit	ions contrib	_	death but no	-	inderlying ca	use given i	in Part I.	23e		icco use contr 2 □ No	ibute to t			
Complet											. Was an autopsy performe	ed?	rior to co l <u>ea</u> th?	opsy findings a smpletion of ca		
ion; To Be	25. Was case referexaminer? 1 Yes 2 27. Manner of Deat 1 Natural	No ath 5 □ Pendi	Hos	28a. Date		2 ER/Outpatie	of 28	Other: 3c. Injury at Work?	1	Home 5	Residen	ce 6 Other		(y)		
Certificati	2 Accident 3 Suicide 4 Homicide	6 Could	tigation d not be mined	28e. Plac build	e of Injury - ding, etc. (Sp	At home, farm, st	m reet, factory,		s 2 □ No	28f. Loca City	ition (Stre or Town,	et and Numbe State)	er or Rura	al Route Numi		
-										occurred at the time, date and place, and due to the restigation, in my opinion, death occurred at the time						
edical	one)		vestigation,	in my opini	ion, death oct	uned at the	time, dat	e and place, a	ind due to	o the cause(s)						

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Richard	
Phillips,	
physician:	
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known	
Name	

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Richard Daniel Phillips 31 2006 3:20 A M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil VA Maryland Health Care System Perry Point If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 57 217-46-5062 Director 10/11/1948 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rthan "natural", or Itams 23a or 28e-f shov the Medical Examiner must be notified at Director MD Montgomery Silver Spring 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11215 Oak Leaf Drive #1410 20904 USA filed withIn 72 hours after death Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No 1968 If Yes, Give 1970 1 Never Married 2 Married , or Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 1970 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Unemployed 12 none other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ss 1 and 2 should be fill of Health and Mental Histem 27 Is marked other Be Frederick Bauer Phillips Jr. Anna Louise Smitley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090411215 Oak Leaf Drive #1410 Silver Spring,MD Anna Phillips/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Importent: If ite
any injury or o 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crem. 6/07/06 Beltsville, Md 4 □ Donation /5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PHILIP D'RINALDI FUNERAL SERVICE, P.A. Alkando 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underving Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-trans resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) P.0. sate has been signed by the a page 2 should be detached: 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 1 No certificate 1 ☐ Yes 2 🛂 No 1 ☐ Yes or Attending Physician: : After this certification of tuneral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 XNo 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner atted. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42800 Camas 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Biondo, MD VA Maryland Health Care System Perry Point, MD 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001 JUN

2006

			1 - For Stata Registrar	State of	Marylan		artmen rtificate			and M		giene Reg. No.	2000	1961	L	
	Physici		1. Decedent's Name (First, Middle, Las Anna F.		Peck						June 5	ath Day	006 Year	3. Time of Death 1:05 A м		
N.	/Medic Examin		4a. Facility Name (If not institution, give Brighton Gardens	street and numb	oer)			Town, or	Location o	f Death		1	County of Death		_	
Ì	Funeral Director		5. Social Security Number 6. S 498-01-8830	ex 7. □M 2□F	Age (In yrs.		If Under Months			24 Hrs. Min.	8. Date of Birt (Month, Da Nov. 2	th y, Year)	9. Birth	nplace (State or Foreigr untry) SSOUTI	7	
e, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mantal Hygiene. Important: If team 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom 10e. Street and Number 5550 Tuckerman La 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grave) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Abraham Friedma 19a. Informant's Name/Relationship (1) Irving Peck — Hus	16a. Decedifie. Give (Give life.) Admin 19b. Mailir 5550	Was Deceded Yes, special Yes, s	Code 20852 lent of Histry Cuba 2X No all Occupant done of the retired, ative (Street at the common of the retired)	spanic Origin, Mexican Specify: ation furing most 2 Assi 18. Mothe	istar istar is Name sther	ncty Yes or No Rican, etc.) ng nt (First, Middle, Lasky I Route Number	U. 16b. Kii U. Maiden ar, City o., N.	S. Gove Sumame) r Town, State, 2 Bethes	rican Indian, a, etc. hite industry rnment ip Code) 20852 da, Md.				
Baltimore			Date Date										Olney, Maryland Chapels, Inc. ille, Maryland 20852			
	Physician // Medical Examiner physician and physician and physician and physician strength	dical Examiner	23a. Pan1. Enter the disease, or composition, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	En ras a conseq Fa	End Stage Dementia as a consequence of: Failure to Thrive as a consequence of: as a consequence of:								Approximate Interval Between Onset and Death		
P.O. Box 68	The law requires that the death certificate be executed to hes been signed by the attending physicien and tage 2 should be deteched for use as the burial-transit	Physician/Med	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown									23d. Date of deli Month	very Day Year			
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al Rec		Completed									1 ☐ Yes	rmed? 2 No	prior to death?	topsy findings available completion of cause of 2 No		
5	Physiclen: Tribis certificeral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	patient 2	ER/Outpatien	4 2F3 DO	Othe			(Check only o		5 □Other (Spec			
ō	g Physter this neral di	n: To	27. Manner of Death	28a. Date of (Month)		28b. Time of		8c. Injury Work	4 E3 Nu		28d. Describe			ary)	_	
Division of Vital Records,	ttendir deeth. stor: Af / the fur	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place o		Injury ome, farm, str	М	101	(? Yes 2∐1		28f. Location (S City or Tox			ral Route Number,		
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical Ce	29a. Certifier 1 To Certifying Ph (Check only 2 Medical Examone)	ysician: To the b ninar: On the bas and manne	is of examina	owledge, death	n occurred vestigation,	at the tim	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier				29c	. License	number			29d. Dat	e signed (Monti	n, Day, Year)		
•	6		30. Na e a d address of person who	1 · O	of death (Iten	n 23a) (Type.		D301	.32			Jun	e 5, 200	06		
	Sta	ate	M. Rita Gho	sh, M. D		12 Phy		ns L	ane,	Suit	e 161,	Roc	kville,	Md. 20850		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan		artment of F tificate of			giene leg. No.	2006	19615				
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Delores Verlett Pe	vton				2. Date of Dea Month May 3	oth Day	006 Year	3. Time of Death 00:55A M				
	Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, o	r Location of Dea			County of Deat	h				
	Funeral		Southern Maryland 5. Social Security Number 579-36-2537 6. Sex		last birthday) Yrs.	Clir If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1	rince (Georges hplace (State or Foreign huntry) nington, D.C.				
Ш,	Director		Usual Residence of Decedent		113.			March 2	U, I	.929wasi	illigion, D.C.				
٠	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits				
	B Mar	ctor	Maryland Prince Ge	orges Caj	pitol H	leights					1 X Yes 2 □ No				
	ith th	Director	10e. Street and Number 403 Ventura Avenue			10f. Zip Code				zen of What Co	ountry?				
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Maryland 21215-0036	be filed within 72 hours after deeth with the Maryland ital Hyglene. Id other than "netural", or items 23a or 28s-f ehow other than "netural", or items 23a or 28s-f ehow event. The Medical Exationer must be motified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 		was Decement of H f Yes, specify Cuba I Pes 2 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Ame Black, Whit Specify: B1a	e, etc.				
Ö	72 ho	ted	15. Decedent's Edui	cation	16a. Deced	dent's Usual Occup	ation	ndring	16b. Kir	nd of Business/	Industry				
7	ithin 1	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Houses	kind of work done OO NOT use retired	d)	, king	n	n/a					
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and	be fill He off	Be	Unavailable					me (First, Middle,							
Ž	should be nd Menta marked imatic ev	ဥ	19a. Informant's Name/Relationship (Ty	oe. Print)	19b. Mailin	a Address (Street			nett Lancaster Number, City or Town, State, Zip Code)						
S	od 2 s lith en 27 is r trau		Roeeda Rhodes /Da	,	1			pitol Hei							
ē,	s 1 ar		20a. Method of Disposition	20b. P	lace of Dispo emetery, cren			cation - City or							
Ê	Par in sp		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	nd hos_	-10-2006 Riverdale Maryland										
altimore,	permit. Pages 1 and 2 should be Department of Health and Mania Important: If tem 27 is marked eny injury or other traumatic evone.		21. Signature of Funeral Service License	e Cr	Latney's	Fur	neral H	ome							
m	88 5 5 8		(Calph William) 3831 Georgia Avenue, N.W. Wash.D.C.20011												
П			Approximate Shock, or heart failure. List only one cause on each line. Approximate												
	Physician		onset and Deal Seating Cause (Final Seaso or condition a. CAOIR AMYHym A												
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	, 0									
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	nsit	nine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 to (0) as a conseq.	derice ory.										
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68			IS SELVANE.							interes and					
Вох	eath certif attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		2	3d. Date of del					
	e dea the at	sici	1 Yes 2 No	4☐ Pregnant at time of d	eath 5□	Other (specify)			i	Month	Day Year				
P.O.	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	adarhina causa an	on in Part I	23a Did to	bacco us	se contribute to	the cause of death?				
Division of Vital Records,	The law requires that the death certi te has been signed by the attending page 2 should be detached for use a	d by	Taking officer of the second o	mouning to doubt but not not	annig ar mo di	idonying cause giv	an mr anti.			oo oo iiinboto to					
Ö	w require been sly should t	Completed						24a. Was a							
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g	ilcian: Th certificate rector, pag	e C	25. Was case referred to medical				26 Place of Do	1 ☐ Yes eath (Check only or		1 🗆 Yes	2□ No				
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0	ttending Phy death. tor: After thi the funeral o		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur Wor		28d. Describe h			,				
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<u>Š</u>	or Attendation of Attendation of Director; in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, tarm, str	eet, factory, office		28f. Location (S City or Tow			ral Route Number,				
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	Hoss 24 hoi Fune tely fi	edical	29a. Certifier 1 Cartifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina	wledge, death tion and/or inv	occurred at the tir restigation, in my o	ne, date and plac pinion, death occ	e, and due to the c surred at the time, o	ause(s) a late and	and manner as place, and due	stated. to the cause(s)				
	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	Med	29b. Signature and title of certifier	and nanner stated.		29c. Licens	e number	2	29d. Date	signed (Monti	h, Day, Year)				
	-)		D0041580 5.30.0								5(0				
	2		30. Name and ad person o completed cause of death (Item 23a) (Type, Print)												
			Dr. Kelso Scot				ton, Mar	yland 20	735						
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa		ede									

State of Maryland / Department of Health and Mental Hygiene 19616 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2006 3:52P. .June Carmen Pineda De1 Vilma /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

67 Yrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 24, 1938 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Nicaragua 1 ☐ M 2 🕱 F 218-17-5717 67 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any july go other traumatic event, the Mudical Exeminer must be rightfied at once. 1 TYes 2 XNo Silver Spring Maryland Montgomery Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20903 Nicaragua 10115 Green Forest Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race · American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married ¹X Yes 2□ No Specify: Nicaraguan Baltimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ana Pineda Francisco Venavente 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1704 Hampshire Green Lane, #301 Silver Spring, Md. 20903 Mario Vanegas -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

1

Method of Disposition

1

Method of Disposition

3 □ Removal from State MD National Mem. Park 6/4/2006 Laurel, Maryland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licentee Donald V. Bor wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 homas 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gastric Cancer Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit that the death certificate be executed Due to (or as a consequence of): physician at s the burial-t Box 68760, iclan/Medical as ettending IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ò in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 5 Other (specify) P.0. the the 9□ Unknown Physi 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes 2 No 1 ☐ Yes 2 ☐ No 1⊟ Yes 25. Was case referred to medical examiner? the funeral director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 $hline 2000 \times 10^{-6} \times 10^{-6$ 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 2 şiq. 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 X Natural 5 Pending investigation М 1 Tyes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D35635 June 4, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20853 32@Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#23a I+II perMD6/6/06,BMW,MbCo Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** June 3,2006 Sang 10:08a /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner 10204 New Forest Court Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Months Days 1 □ M 2X F 83 Yrs. 212-82-6563 12/18/1922 Korea Director Usuel Residence of Decedent parmit. Peges 1 end 2 should be filed within 72 hours eftar death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23e or 28e-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Howard Ellicott City Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 10204 New Forest 21042 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Asian 1 ☐ Yes 2 ☑ No Specify: þ 3₺ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gueon Young Choi Park 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Augustine Paik/Son 9800 Glynshire Way Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Pk 6/05/06 Timonium, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of peral Service Licen e PHILIP D'. RINALDI FUNERAL Service, p.a. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Pert1. Enter it e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 2 yrs. Examiner Examine To the Hospital or Attending Physician: The law requires that the death certificate be asscuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Ascites þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed Anemia 2 X No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ TEXES 2 No 27. Menner of Death 28d. Pescribe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending NA 1 Tes 2 ANO investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.5 D33979

Registrar

State

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31. Dete filed (Month, Day, Year)

JUN

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30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print)

2006

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32 /Registrer's Signature

Theodore

NEVAH. Paul 06-03864 UNK UNK

Please Type or Print in Black Indelible Ink

INK UNK	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	961										
Physician/ ledical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Mostly And Decedent's Name (First, Middle, Last)											
	4a. Facility Name (if not institution, give street and number) St. Pauls Church Road 4b. City, Town, or Location of Death Marion 4c. County of Death Somerset											
Funeral Director	5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) Months Days Hours Min. 07-08-1958 Foreign Country) 9. Birthplace (State Foreign Country) 1 Usual Residence of Decedent	e or										
Aaryland 28a-f show any 1 at once. ector	10a. State 10b. County 10c. City, Town or Location 10d Inside MD Carroll Hampstead 1 V Ves											
h the Maryland 3a or 28a-f sh ottified at onco	10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1364 North Main Street 21074 USA											
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, E White, etc. 15. Was Decedent Ever in U.S. 16. Armed Forces? 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Yes 2 No specify: Specify: White	llack,										
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner To Be Completed by I	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry during most of working life. DO NOT use retired)											
21215-0036 uld be filed within ? Mental Hygiene. marked other than e eveut, the Medica TO BE COMPIE	To. Mother's Teams (1 list, Middle, Maider Surfame)											
ID 21215-005 should be filed within and Mental Hygiene. 7 is marked other to natic event, the Med To Be Comp												
st and 2 shou 2 shou of Health and N If item 27 is ner traumatic	Daniel John Paul - Son 412 Oak Hill Ct., Apt. B-2 Westminster, MD 2 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State	1157										
·= 6 2 0 1	1 X Burial 2 Cremation 3 Removal from State department of the place of											
Balt permit Depart Impor injury	21 Signature of Funeral Service Ligensee MOO550 22. Name and Address of Facility Eline Funeral Home 934 South Main St., Hampstead, MD 210 23. First, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
Physician /Medical Examiner	Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Death Death											
	quentially list conditions, ny, leading to immediate b											
amine												
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760, icate be execuphysician and the burial - tra	IF FEMALE: 23d Date of delivery											
D. Box 687 true death certific by the attending packed for use as the Physician/	past 12 months? The birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year										
S, P.O. uires that the signed by ld be detached by Pedeby Pedeby Pedebby	1 Yes 2 No 3 Probably 4 1	Unknown										
Records, The law require: ficate has been sig, page 2 should be Completed	24a Was an autopsy finding prior to completion of performed? 1 ✓ Yes 2 No 1 ✓ Yes 2											
rital Resistant The is certificate lirector, page	25. Was case referred to medical 26. Place of Death (Check only one)											
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending I to the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the edical Certification: To Be Completed by Physician/	(V 198 2 NO											
Divison Aprilements of Aprilements o	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) St. Pauls Church Road, Marion, MD	nber, City										
Division To the Hospital or Attent within 24 hours after death withe Funeral Director: completely filled in by the	29-a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as started. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started.											
MI	29b. Sygnature and title of certifier 29c. License number O. C.M.E. 29d. Date signed (Month, Day, Year)										
4	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
State Registrar												
DHMH 17 Rev 1/2001	- Aprila											

Amended Item 10b per F.D. 06/09/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 116 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 1145 2006 1 une Dayid /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City Johns Hopkins Hospita Himo/ If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days 1**∑**M 2□ F Diréctor 62 1943 West Virginia 233-66-9885 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County itema 23e or 28a-1 show or other traumatic event, the Madical Examiner caust be notified at York 1 Yes 2 □ No Director -Hanover Hanover Penn. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Itema 23e and Injury or other traumatic event, the Modical Examination 2006. 17331 USA 317 West Elm Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 5 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Truck Driver General Motors 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ervin James Poling Olga Mae Norman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paula Poling Wife 317 West Elm Ave., Hanover, PA e of Disposition (Name of Date 20 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6/10/06 Meadow Branch Cemetery Westminster, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 2 days /Medical Due to (or as a consequence of): Examiner Neutropenia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit cell Mantle that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No page 2 s nis certificate h I director, page 25. Was case referred to medical examiner? 86 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury ospital c.
4 hours after deal.
-rai Director: After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier RES-000 MZV MO 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital 600 North Wolfe Street Bethimore MD Z1287
32. Applistrar's Signature

06 June & July Kristi Mizelle The 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

State

Registrar

JUN 0 9

2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 4, Dolores Α. Parkerson 2006 8:15 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Edgewater South River Health & Rehab. Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, NOV 5, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2 🕅 F **7**5 Washington, DC Director 579-36-4787 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Mcdical Examinar must be notified at 1 Yes 2 No Director Dunkirk Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20754 TISA 9981 Howes Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other then "natural", or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: δ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Administrative Asst. 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Tucci ٥ Rose Arnone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 sh Depertment of Health and Importent: If Item 27 Is rr eny injury or other traum once. 20754 Dunkirk, MD Jean Douglas (daughter) 9981 Howes Road 20b. Place of Disposition (Name of cemetery, crematory or other place) June 8 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 2006 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Ineral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Owings, MD 20736 8125 Southern Maryland Blvd. Gary J. Soff 23a. Part1. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use es the burial-transit certificate be executed authoro Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð cete hes been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete hes autopsy performed? 20 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred After Hospital or Attending **T** □ Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 5, 2006 death (Item 23a) (Type, Print) Workidaely 32. Registra Signature State 2008 Registrar

		4	For Amend Item 2 1 - State Registrar	States of Marylan	Cer	08/2 tifica	te of D	hth ar Death	nd Me	ental H	lygie Reg		06	19621		
			1. Decedent's Name (First, Middle, Last)						2	2. Date of Month	Death	Day	Year	3. Time of Death		
	Physici		David	William	Peni	n.	Jr.		J	fune	1,	2006	· oai	10:30 p M		
	/Medio Examin	_	4a. Fecility Name (If not institution, give si					ocation of	Death			4c. County	of Death			
	- Admini	•	2601 Dogwood Lane				Owin	ngs				Cal	vert			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Unde		If Under 24	4 Hrs. 8	B. Date of (Month,	Birth Day Y	ear)	9. Birthp	lace (State or Foreign		
и	Director		215–36–3580 ¹ X	^{M 2□ F} 66	Yrs.	MOUTUS	Days	Tiodis		July	30,	1939		h., D.C.		
	P .		Usuel Residence of Decedent											Ad Incide City United		
	ahow ahow	L	10a. State 10b. County	10c. Ch	ty, Town or Lo	cation							'	0d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	Ba-f a	5	MD Calvert				Owi	ngs								
	or 2	Director	10e. Street and Number			10f. Zi	p Code				10g	. Citizen of W	hat Cour	ntry?		
	23a		2601 Dogwood Lane				207					USA				
	ep .	Funeral	11. Maritar Otatos	Was Decedent Ever in U Armed Forces?	I.S. 13. V	Was Dece I Yes, spe	dent of His orly Cuban	panic Origi , Mexican,	n? (Spec Puerto Ri	ify Yes or ican, etc.)	No-		- Americ c, White,	an Indian, etc.		
36	within 72 hours after death with the Maryland ene. then "natural", or lleme 23a or 28a-f show he Madical Examina must be notified at	by F	1 Never Married 2 Married	1 ☑ Yes 2 ☐ No If Yes, Give		1 🗆 Yes	2 ∑ No	Specify:				Specify:	r thá	±0		
21215-0036	ural'	g D	3 Widowed 4 Divorced	Year or Dates:1959-	1	damila I la	al Ossumat	lian			16	b. Kind of Bu	whi			
7	"nat	lete	15. Decedent's Educ (Specify only highest grade			kind of w	ork done du use retired)	uring most o	of working	9	10	b. Kind of bu	211162271116	uustry		
12	withis	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ne ma						const	ruct	ion		
D	Hygid ther		17. Father's Name (First, Middle, Last)		500	IIC III		18. Mother	s Name (First, Midd	die, Ma	iden Sumame		1011		
an	d be	9 Be	David William	Penn				Doro	othy		May	А	rner			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23a or 28a-1 show any injury or other treumetic event, the Madical Examinat must be notified at ance.	ို	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Addres	s (Street ar					ity or Town, S		Code)		
∑	d 2 s th an t7 ie treu			_	2601											
ė,	Heal Heal	1 6	Mary Ann Penn, wif	20b. F	Place of Dispo	sition (Na	me of		Da			c. Location -	City or To	own, State		
9	ages nt of r: If it	l i	1 Burial 2 Cremation 3 Re	emoval from State	cemetery, crer tropol:	•			06 (7 06	7	l ovand	ria	777		
Baltimore,	rtani rtani		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		-		and Address		00-0	77-00	A.	rexamu.	LIA,	VA		
Ba	Depe Impo eny ir		1 100 cm 3	6					TToon	. D	71	Orzina	~ 1/	D 20726		
			23a Part 1 Enter the disease or complic	ations that caused the deal									S, M	Approximate		
			shock, or heart failure. List only on Immediate Cause (Final	shock, or heart failure. List only one cause on each line. Interval Betw. Onset and D												
	Pnysician /Medical		disease or condition resulting in death)	Pancrea		and	er		11				1	o mordis		
	Examiner			Due to (or as a consequence of):												
		ا <u>ه</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):												
	ted	듣	cause. Enter Underlying Cause (Disease or injury	VED BY MEDICAL								T FYA				
	xecu al-tra	Examin	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):	CERTIFICAL VED BY MEDICAL EXAMINER										
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687	ficate phy: s the	oibe														
	death certifica e attending ph id for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregn								23d. Date	ol delive	ery		
Вох	atte for t	ciai	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		_lEctopic ¡] Other (s	pecify)					Mor	ith	Day Year		
P.O.	0 0 2	ysi	9 Unknown	9□ Unknown								1				
	requires thet the leen signed by th hould be deteche	by Pi	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying	cause give	n in Part I.		23e. D	id tobac	cco use contri	ibute to th	ne cause of death?		
ds	uires n sign	D D	Bladder ca	ncer						1	☐ Yes	2 XNO	3 Prob	ably 4 Unknown		
Ö	> D 0	Completed	Dan loso							24a. W	tasan	24b. V	Vere auto	psy lindings available		
Re	The law ate has b page 2 st	臣	- who pregnate							p€	artopsy artorme	d? a	rior to co eath?	mpletion of cause of		
of Vital Records,	icien: Th certificate ector, pag	ပိ	25. Was case referred to medical					26. Place o	of Dooth	1 Ye		No 1	☐Yes	2 No		
₹		00	examiner?	ospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	nt 3 🗆 C	Othe	c				e 6 □Othe	r /Specif	vl		
ō	Physic this stal dis	. To	27. Manner of Death	28a. Date of Injury	28b. Time o		28c. Injury Work			,		injury occurre		,,		
O	iding Ph th. : Alter the funeral	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м		? ′es 2 ∐ N	o							
Division	if or Attending after death. Director: After d in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	nome, larm, str	reet, lacto	ry, office		28	BI. Locatio	n (Stree	et and Numbe	r or Rura	I Route Number,		
á	after Dire	Certification:	4 Homicide	building, etc. (Speci	rty)				1	City or	rown, s	Srare)				
	Hospital or, 24 hours after Funeral Dire Funeral Dire intely filled in b	edicai C	(Check only 2 Medical Exemin	sicien: To the best of my kn ner: On the basis of examin												
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner stated.		2	9c. License	number			294	. Date signed	(Month	Day, Year)		
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			100 von Helse	age (M)			210	000				0	200	<u>u</u> ,		
1	クエリ		30. Name and address of person who co	11			O.L.	111	Dec.		ha = "	and -1	**	20670		
	2+1		Robert Schlager, 1 31. Date liled (Month, Day, Year)	M.D., 110 HOS	SPITAL ature	Ka.,	ste.	111,	Pri	nce F	rea	erick,	MID	ZU0 / 8		
	St Regist	ate rar	JUN - 6	32. Registre's Sign	es &	60	Mes									

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician JUINTEL 2006 AMILO 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST KOCKVILLE HOSPITAL MONTGOMERY If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 X M 2□F Yrs. Director NONE 05 25 12006 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 □ No Director MD MONTGOMERY NORTH BETHESDA 10e. Street and Number #125 10f. Zip Code 10g. Citizen of What Country? other than "naturel", or iteme 23a or rent, the Medical Exerciper must be OLD GEORGE TOWN KOAD 20852 1170 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo δ Specify: 3 □ Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) INFANT None permit. Peges 1 and 2 should be filled v
Department of Health end Mental Hygies
Important: If item 27 is marked other tt
any njury or other traumatic event, III.a. Ø 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ZUINTELA GOMEZ-ULLA ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD OLD GEORGE OWN FILAR GOMEZ-ULLA MOTHER 1170 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 200 Cremation 3 Removal from State 6/6/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Simple Tribute 1040 Rockville Pike; Rockville, Maryland 20852 23a. Part1. Enter the disease, or objections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, an eart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ENTEROCOLITIS ECROTIZING Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 K No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy 2 No 1 ☐ Yes Director: After this certification by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. fnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No death. 3 Suicide 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29b. Signature and title of de 29c. License number 29d. Date signed (Month, Day, Year) 51461 person who completed cause of death (Item 23a) (Type, Print) CENTER DRIVE, RUCKVILLE, MD 20850 9901 MEDICAL KOST. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JUNE 2006 DONALD BURTON ROE 7:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CAROLINE RUXTON HEALTH OF DENTON DENTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
DEC 12, 1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1X M 2 F MARYLAND 74 Yrs. Director 214-28-8685 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ehow if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehov other traumatic event, Ire Modical Examiner must be notified at Yes 2 No Completed by Funeral Director PRESTON CAROLINE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 21655 USA 118 SUNSET BLVD. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 □ Widowed 4 □ Divorced WHITE Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 MACHINE OPERATOR NYLON MANUFACTURER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANK LEE ROE ETHEL MAY CHEEZUM ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDITH A. ROE/WIFE PO BOX 152 PRESTON, MARYLAND 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of himportant: if ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State PAUL'S CEMETERY 6/6/2006 CORDOVA, MARYLAND ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses PALLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON WHOL F. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between SERSIS Onset and Death Immediate Cause (Final SYNDROME Physician DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RAY NECATIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit URINARY that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be WRONIL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perform 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident efter death i Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitai within 24 hours of To the Funaral 29a. Certifier 1 S-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and the of certified 29d. Date signed (Month, Day, Year) MD-ATTENDING DOO who completed cause of death (Item 23a) (Type, Print) s of person 31. Date filed (Month, strar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene) - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:39 P^M RICH JUNE 1, 2006 HELENE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner SILVER SPRING HOLY CROSS HOSPITAL MONTGOMERY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number **Funeral** Months Days Hours 1 □ M 2 😡 F 67 Yrs. 261-54-2570 NOV. 6, 1938 NYDirector Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 √Yes 2 No Director ROCKVILLE MD MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö permit. Pages 1 and 2 should be filed within 72 hours after deeth v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a eary injury or pher traumatic event. If a temperature is a force. 5517 AMESFIELD COURT 20853 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2♥ No 1 Never Married 2 TMarned 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 MORRIS BEUBIS PEARL SHAPIRO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HUSBAND MARK RICH 5517 AMESFIELD COURT, ROCKVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State JUDEAN MEMORIAL GDNS 06/04/2006 OLNEY, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC ENCEPHALOPATHY /Medical Due to (or as a consequence of): Examiner CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed ASPIRATION PNEUMONIA Due to (or as a consequence of): Box 68760, Physician/Medical А IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I ħ ۵ s been signed to should be detail 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown MULTIPLE MYELOMA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 Yes 2 🔀 No Division of Vital Hospitel or Attending Physicien: To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0061937 JUNE 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND CANDICE L. WILSON, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2006 Registrar

		1 - For State Registrar		State o		ind / Dep	ertificate of	lealth a	and Mental Hy	/gien Reg. N	2111	6	196	25		
Phys	sician	Decedent's Name (First	t, Middle, Las	st)					2. Date of D Month	D		'ear	3. Time of De			
/Me	edical			l Roach			45 Ch. Town	.1	June			Donth	6:52 P	М		
Exa	miner	4a. Facility Name (If not in Greater B				nter	4b. City, Town, o	owson			c.County of Baltir					
F		5. Social Security Number				s. last birthda	If Under 1 Year	If Under				. Birthpl	ace (State or F	oreign		
Fune Direct		217-26-5697		™ 2□F	81	Yrs.	Months Days	Hours	Min. Jan. 5	ay, Yea	25 W	est	Virgini	a		
p .		Usual Residence of Dece			100	City, Town or I	osstina.					4/	0d. Inside City L	imita		
laryla shov			County Larford	ľ	100.	•	de Grace						od. mside City t 1 ☐ Yes 2			
the M	Director	10e. Street and Number	- LOTO			110010	10f. Zip Code			10a. C	itizen of Wh	at Coun				
3a or		139 Hopk	ins Ro	ad			21078				.s.A.		,			
death with the Maryland ms 23a or 28a-f show	Funeral	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13			igin? (Specify Yes or N n, Puerto Rican, etc.)		14. Race -	America White, e				
5-0036 72 hours after insturel; or ite	J.T.	1 Never Married		1 X Yes If Yes, Gi	2 No ve		1 ☐ Yes 2 No				Specify:					
21215-0036 od within 72 hours att gjene.	od be	3 ☑ Widowed 4 □ C	oivorced Decedent's Ed	Year or D	ates:WWI]	1	edent's Usual Occup			165	Kind of Busi					
115-	Completed	(Specify on	ly highest gra	de completed)	4 4 2 5 . 3	(Giv	e kind of work done DO NOT use retired	during mos d)	t of working							
Billing atthing all Hygiene.	E O	Elementary/Secondary	(0-12)	College (1-40r 5+)	Lal	orer			Mai	intana	nce/	'mechani	LC		
nd 2	Be	17. Father's Name (First,	Middle, Last)					18. Mothe	er's Name (First, Middle, Maiden Sumame)							
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Maryland Maryland 2 should be lift in and Mental Hy it is marked oth	14	19a. Informant's Name/F				1	77		er or Rural Route Numi			ate, Zip	Code)			
re, N 1 and 1 and Heetth tem 27		Bill L. Roa	<u>-</u>	• (5011)		. Place of Dis	8 B Ady Ro		Street, MD	_	154 Location - Ci	ty or To	wn, State			
mor Pages Pages Int. If it.					State Be				6/17/06	Ве	l Air	. Ma:	rvland			
그 등은 등	once.		Date 20c. Location - City or Town, State completely, crematory or other place) Date 20c. Location - City or Town, State completely, crematory or other place) Bel Air Mem. Gdns. 6/17/06 Bel Air, Marylai 22. Name and Address of Facility. Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001—3399													
		23a. Part1. Enter the dis	ease, or com	plications that of	caused the de						99		Approximate			
Physicia	20	shock, or heart failt Immediate Cause (Final	ıre. List only	one cause on e	each line.	11							Interval Betwee Onset and Dea	in .th		
Physicia /Medic		disease or condition resulting in death)	-	a. Due to	(or as a cons	equence of):~						+				
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N 9 5	iner	if any, leading to immedicause. Enter Underlying	luxa			1										
60, 4.	Examiner	that initiated events resulting in death) Last	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
0 50	Ca	resulting in death) Last Due to (or as a consequence of):														
S, P.O. Box 68 es that the death certifica igned by the attending pheneforms as the beneformers as the	by Physician/Med	IF FEMALE:		23c. If yes, ou	taoma of pro-											
BO Bath o	clan	23b. Was decedent preg in the past 12 mont		1☐Live t	pirth 2 ☐ Fe nant at time o	etal death 3	☐Ectopic pregnancy	y			23d. Date of Month		ry Day Yea	r		
.O.: the d	hysi	1 Yes 2 No 9 Unknown	-	9□ Unkn												
S, P	V P	Part II. Other significant	•			_	underlying cause giv	en in Part I	. 23e. Did	tobacco	use contrib	ute to th	e cause of deat	h?		
ecord: law require las been sil	ted	KES	PIYUTI	URY 1 - FAT	71/20	1/28			1□	Yes :	2 □ No 3	Proba	ably 4 Unk	nown		
lecc law r	Completed	RE	NAC	- 11	LUR	E			24a. Wa	opsy	pric	or to con	osy findings ava npletion of caus	ilable e of		
al H	් දු								1 ☐ Yes	ormed?	lo 1	ath?] Yes	2 No			
Vita	Be C	25. Was case referred to examiner? 1 Yes 2 No	medical	Hospital:	Inpatient 2		ent 3 DOA Oth	ar	of Death (Check only		2 (70)					
of g Phy er this	n: T	27. Manner of Death		28a. Date	of Injury	28b. Time	of 28c. Injur	4 140	ursing Home 5 Res 28d. Describe				"			
sion anding ath.	atio	2 Accident	Pending investigation	n	th, Day Year)) Injury		Yes 2	No z							
Division of Vital Records, P.O. Box to attending Physicien: The law requires that the death cert after death. Director: After this certificate has been signed by the attending to be the fundal director, canal 2 should be delached for use	Certification:	3 Suicide 6 Suicide	Could not b determined	200. Flace	of Injury - At ing, etc. (Spe	t home, farm, s	street, factory, office		28f. Location City or To			or Rural	Route Number			
Division of Vital Records, P.O. Box 68 To the Hospitel or Attanding Physician: The law requires that the death cardifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the Innext director page 2 should be detached for use as the	Medical C	29a. Certifier 12 (Check only 2 one)	Certifying Ph Medical Exar	niner: On the b	asis of exami	nowledge, de ination and/or	ath occurred at the tir investigation, in my o	me, date an	nd place, and due to the oth occurred at the time	cause(s) and mann	er as sta	ated. the cause(s)			
o tha ithin 2 o the	Med	29b. Signature and title of	of certifier	And man	iner stated.		29c. Licens				ate signed (
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浴		30. Name and address o	person who	completed cau	se of death (I	om 23a) (Typ	e, Print) U Charl	lesSt	728 (MD) SKSSO	TOU	usan	M	2120	1		
-	State	31. Date filed (Month, Da		4	Registrar's Sig	gnature						. , .				
	istrar	JUI	V212	006		11 1	mell									
DHMH 17 Re	v 1/2001		-			ORIO	GINAL									

			State of Maryland / Department of Health and N State Registrar State of Maryland / Department of Health and N Certificate of Death		giene Reg. No.2	06	19626						
	Physicia	an	1. Decedent's Name (First, Middle, Last) Sharon M. Saffron Robinson	2. Date of Dea Month	Day	Year	3. Time of Death 2:22 PM						
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	May 31		y of Death	Z: ZZ F						
	Examini	ei	Suburban Hospital Bethesda			gome	ry						
	Funeral Director		5. Social Security Number 263-39-7502 6. Sex 1 M 2 K	8. Date of Birt Sept. 3	1957	9. Birth	place (State or Foreign ntry) Orida						
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits						
	with the Maryland a or 28a-f ahow be notified at	ctor	Maryland Prince Georges Bowie				1 X Yes 2 □ No						
	vith the	Dire	10e. Street and Number 10f. Zip Code 20721		10g. Citizen of United		•						
	ns 23a	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-		ce - Ameri	can Indian,						
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f ahow aumatic avent, the Modical Examinar wat be notified at	by Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Never Married 2 Married I S S 2 Mo 1 Yes 2 Mo Specify: 3 Widowed 4 Divorced Year or Dates:	Hican, etc.)		ick, White, _{fy:} B1a							
5-0	72 hor	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work done	king	16b. Kind of E	Business/Ir	dustry						
121	within liene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney		Law								
and 2	t be filed within 72 hountal Hygiene "natural ed other then "naturals event, the Modical E	Be											
يَّ	should nd Mer mark umaric	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		r, City or Towr	, State, Zij	c Code)						
, Ka	and 2: ealth ai th 27 is		Oliver A. Robinson (husband) 3404 Spectacular Bid (207							
Baltimore, Maryland 21215-0036	Pages 1		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery June	Date 6, 2006	20c. Location								
Balti	permit. Pages 1 and 2 should by Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic avonce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCo 7400 Georgia Ave. I				ce 0012						
•	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer Due to (or as a consequence of): b. Cue to (or as a consequence of):	or respiratory ar	rest,		Approximate Interval Between Onset and Death 5 years						
2.PM 68760,	rificate be executed g physician and as the burial-transit	edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Cue to (or as a consequence of): c. Due to (or as a consequence of): d.	_									
06 2:3;	death cei e attendir id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown	and the second		ate of deliv onth	ery Day Year						
3; F	Se de	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use cor res 2X No		he cause of death?						
Sufficen of Vital Record	aw d s d s	Completed		24a. Was autop perio 1 Yes	rmed?	Were autoprior to codeath?	opsy findings available impletion of cause of						
出版	Physician: this certifica ral director, r	Be	25. Was case referred to medical examiner? 1 Yes 2 \frac{1}{X} \text{No} \frac{2}{1} \frac{1}{X} \text{Inpatient} 2 \frac{1}{2}		/0	4.4							
7 5	inding Physath. rr: After this re funeral di	tlon; To	1 Yes 2 Xno 1 Inpatient 2 Fr/Outpatient 3 DOA 27. Manner of Death 1 Xnetural 5 Pending 2 Accident investigation 1 Inpatient 2 Fr/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	ome 5 ☐ Residence 1			'y)						
Sheren N Division	l or Attan after deal Director:	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox		ber or Rur	al Route Number,						
Sine	Hospita 24 hours Funarai tely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the red at the time,	cause(s) and n date and place	anner as s , and due t	stated. o the cause(s)						
	To the Within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number		29d. Date sign	ed (Month,	Day, Year)						
	+		30. Name and address of orson who completed cause of death (Item 23a) (Type, Print)		June	1, 20	06						
			Carolyn B. Hendricks, M.D. 6410 Rockville Drive, Sui	te 506,	Bethes	da, M	D 20817						
	Sta Regist	ate i rar	31. Date filed (Month, Day, Year) 32 Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For TCHD, 6/8/06, sbb Registrar Amended#31,per-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3 2006 22:24 June 0de11 Smith Walter /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore - Washington Medical Cen Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**⊠**M 2□F 43 4 1962 Maryland Director <u> 215-76-0302</u> Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23s or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Talbot Trappe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4333 Lovers Lane USA 21643 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Item Construction Construction Worker 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Warkins Lorrine Walter Adkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Stanford / mother 4333 Lovers Lane, Trappe, Maryland 21643 Lorraine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of Himportant: If Ite any injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State Richards Memorial Pk. 06-10-2006 4 ☐ Donation 5 ☐ Other (Specify) Easton, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home
426 Dover Street, Easton, Maryland 21601 permit. 21. Signature Huner I Survice Licensee Approximate Interval Between Onset and Death 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Se if a Ca Ca tha res

Examiner or Attending Physician: The law requires that the death certificate be executed anding physicien a use as the burial-Physician/Medical Completed by Be Certification: To After death. s efter death filled in by the within 24 hours e To the Funerel L Hospital cal Medic

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant condition	ons contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknow

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an meo! 2□ No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 | ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 5 Pending

27. Manner of Death 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and live of certifier 29c. License number

of person who completed cause of death (Item 23a) (Type, Print)

2 🗆 No

State

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To the

				artment of Health and Me	ntal Hygier	6000	19628
1		ž.	1. Decedent's Name (First, Middle, Last)	2	Date of Death	Day Year	3. Time of Death
	Physicia /Medic	-	Henry Aloysious Smi	th, Jr.	June 10,	2006	8:30 P M
%	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
3/67		1	20526 Piney Point Road	Callaway		St. Ma	ary's
	Funeral Director		5. Social Security Number 6. Sex 1 $\frac{1}{M}$ M 2 \square F 7. Age (In yrs. last birthday 66 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea (Nomber 22,	9. Birth Cou 1939 Ma	place (State or Foreign intry) ryland
	2		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L				40d Inside City Limite
	within 72 nours after death with the maryland than "natural", or tems 23a or 28a-f show the Modical Extrafrer must be notified at	_					10d. Inside City Limits 1 ☐ Yes 2 No
	8a-1-	Directo	Maryland St. Mary's Callar				
:	or 2	Dire	10e. Street and Number	10f. Zip Code		Citizen of What Cou	intry?
	238		20526 Piney Point Road	20620		ISA	
	er ma	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
S.	orli	by Fi	1 ☐ Never Married 2 Married 1 Married 2 No If Yes, Give	1 ☐ Yes 2 X No Specify:		Specify: VII	•
ġ	ural.		3 Widowed 4 Divorced Year or Dates:	d-Na Usual Occuration	101		ite
<u>.</u>	nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation e kind of work done during most of working DO NOT use retired)	160.	Kind of Business/li	ndustry
7	then then	m l	Elementary/Secondary (0-12) College (1-4or 5+)	ply Technician	II	S. Governme	nt
7	be lied within 7.2 nouts after death with the marylar to Hygiene. Id other than "natural", or liems 23a or 28a-1 show event, tre Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)	18. Mother's Name (
ä	ntal h	Be		Lillian A			
Maryland 21215-0036	s 1 and 2 should by if Health and Menta item 27 ie marked other traumatic e	ို	Henry Aloysious Smith, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural I			n Codel
Z	nd 2 sho lith and 27 ie m		1111	6 Piney Point Road, Call			p 000e)
ი _	Health Health em 27 ther to			osition (Name of Dat	e 20c.	Location - City or T	own. State
ૅૂ			Laboutal 2 Cremation 3 Nemovarion State	osition (Name of paratory or other place) June		ŕ	
altimore,	rtmer rtent njury			morial Gardens 14, 2	ub Leo	nardtown, M	aryland
Ba	permit. Page Department i Important; if any Injury or once.		21. Signature of Furieral Service Licensee	attingley-Gardiner Funer .0. Box 270, Leonardtown	al Home, P	-A_C=0	
			23a. Part I. Enter the disease, of complications that caused the death. Do not en			20050	Approximate
			SHOCK, OF Heart failure. List only one cause on each line.	ner the mode of dying, sacras cardiac of the	espiratory arrest,		Interval Between Onset and Death
-	nysician		Immediate Cause (Final disease or condition resulting in death)	nomaloses			40
	/Medical Examiner		Due to (or as a consequence of):	Nonnan			T'2
	ZXUITITICI		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	(Bonne)			4)
	sit a	ine in	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury				()
	and -tran	Examin	resulting in death) Last Due to (or as a consequence of):				•
90	tate be executed by sician and the burial-transit		buo to (or as a consequence or).				
8760	certificate be executed diding physician and ise as the burial-transit	dicai	d				
9 X O	attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			0015 115	
80	atter for L	ian	in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deliver Month	ory Day Year
o	0 0	ysic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown 9 Unknown	Other (specify)			
٠.	The law requires that the de tie has been signed by the a page 2 should be detached to		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
က်	signe 3 be d	by			⊁ Yes		bably 4 □Unknown
Ö	w require been si should t	Completed			-		
ec ec	alaw hast e 2 s	npi			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
=		Co			1 ☐ Yes 2 🖫	No 1 ☐ Yes	2□ No
ite 	sician: In certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)		
5	Physic this c aldin	0	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			6 □Other (Speci	fy)
ב	ong t	 	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	Work?	d. Describe how in	nury occurred	
<u>s</u>	death. ctor: A y the fu	cat	2 Accident Investigation 3 Suicide 6 Could not be 280 Blace of Injury. At home farm of	M 1 Yes 2 No			
Division of Vital Records,	ne Hospital or Atten n 24 hours after deat ne Funeral Director: bletely filled in by the	Certification:	4 ☐ Homicide 3 ☐ Solidation Sol	treet, factory, office	f. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
	urs a						
	To the Hospital within 24 hours a To the Funeral to completely filled	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only 2 ☐ Medical Examiner: On the basis/of examination and/or i	th occurred at the time, date and place, an nvestigation, in my opinion, death occurred	d due to the cause at the time, date a	o(s) and manner as a and place, and due	stated. to the cause(s)
	vithin 2 To the complet	Med	one) and manner stated. 29b. Signature and title of gentier	29c. License number	294	Date signed (Month	Oay Vasc)
	1 × 10 0	_	250. Signature dire title of goriffied	M P DKII	19	Date signed (Month)	j, redij
8	M		James James	11) 2004	1/6	7100	0
0	N		30. Name and address of person who completed cause of death (Item 23a) (Type	•			
	8. 10		James P. Jarboe, M.D. 24035 Three Notch Ro	ad, Hollywood, Maryland	20636		
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	ork			

State of Manyland / Department of Health and Mental Hygieng 0.00

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- 5	Jul.	n	1	See

				State of Ma	ir y latia i	Certifi	icate of L	Death		Reg. No.	JUO	191	0 4 5
	Dharisis		1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	eath Day	Year	3. Time o	f Death
-	Physiciar /Medica		Peggy Ann	Smith					June	4 2006	5	6:15	PM
-	Examine	r	4a Fecility Neme (If not institution, giv				4	b. City, Town, or L		h 4c. Cour	nty of Deeth		
			502 Robinson S			series y IF	Under 1 Year	Salisb			comic		<u> </u>
	Funeral Director		5. Social Security Number 218-30-1208 Usual Residence of Decedent	^{ex}	(In yrs. lest		onths Days	Hours Min.	8. Date of Bir (Month, Date Aug. 2)	ny, Year) 9 1935	9. Binni Coul Mar	olace (State ontry) yland	or Foreign
	show de		10a. State 10b. County		10c. City, T	own or Locatio	on				1	10d. Inside C	
	Ne M	2	Maryland Wicom	ico	Sa	alisbu							22X INO
	with the	5	10e. Street and Number			110	0f. Zip Code			10g. Citizen o	of What Cou	ntry?	
	eath 23	ā	502 Robinson S	treet 12. Was Decedent E	ver in IIS	13 Was	Decedent of Hi	21801	acify Vac or No	U.S.	A ace - Americ	ean Indian	
21215-0020	permit. Peges 1 and 2 should be filad within 72 hours after death with the Manyland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumstic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			s, specify Cuba Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Spec	lack, White,	etc.	
2-0	22 ho		15. Decedent's Ec (Specify only highest gre	ucation	1	6a. Decedent's	s Usual Occupa	ation	kina	16b. Kind of			
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2	ad wi	5		5+		Teac	her			None			
pu	d oth	8	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle	, Maiden Sum	ame)		
Maryland	Men Men	<u> </u>	Benjamin Dorma						Emma I				
Nar	2 sh end is m		19a. Informant's Name/Relationship (and Number or Ru				Code)	
	1 end Health im 27 ther 1	-	Zanita Curtis (20a. Method of Disposition	Daughter		002 Ro	Dinson	St.Sal				Ct-t-	<u>-</u>
ŏ	or of	-	1 Burial 2 □ Cremation 3 □	Removal from State			n (Name of ry or other place	1.6	Date	20c. Location			
Baltimore,	it. Pertrant:		4 Donetion 5 Other (Specify	·	Head		reek C		11/06	Salis	bury	,Md.	
Ba	permit. Pege Depertment of Important: If eny injury or pnce.		21. Signature of Funerat Service Licer **Eladus Bi	Stewar	1			Funeral Rd. Sa		ry,Md.	21801	1	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	ofications that caused one cause on each line	the death. [Do not enter the	e mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximat Interval Bet	e ween
	Physician										1	Onset and I	Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	е.		DEMER	VITA					54CA	13
		_	resuming in death)	[Due to (or as	a consequenc	ce ot):						
	lad sit	Examiner		b									
	ifficate be executed g physician end es the burial-transit	Xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as	a consequenc	ce ot):						
68760,	be e Sician buris	2	cause. Enter Underlying Cause (Disease or injury	c									
687	icate phy:		resulting in death) Last	C	ue to (or as	a consequenc	e of):				1		
Вох	ath certification attending for use e	2		d									
m	The law requires that the death certificate be executed ate has been signed by the attending physician end pege 2 should be datached for use as the burial-transit communicated by Dhysician Machinel Exempton	20	Part ti. Other significant conditions or	potributing to death but	t not recultin	g in the under	vice cours aius	on in Part I	22h Did	tobacco use o	ontributo te	the course	of death 2
P.O.	by the ache	3	ranti. Other significant conditions of	ontributing to death but	t not resultin	g in the under	ying cause give	mmranı.		Yes 2 No		bably 4	
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Records,	requires that the de been signed by the should be datached					٠,				an autopsy	24b. W	ere autopsy f ailable prior t	indings
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æ	he law te has ege 2								10	Yes 2⊠No	1.]Yes 2□	No
ita	ician: The i certificate he rector, pege		25. Wes case referred to medical					26. Place of Dear	th (Check only o	one)			
of Vital	Z 00 0	o I	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	it 2□ER/	Outpatient 3	□ DOA Othe	Ne:	ome 5 Resid		ther (Specif	y)	
0	g Ph ter th nerel		27. Manner of Death 1 ☑Naturat 5 ☐ Pending	28a. Date of trijung (Month, Day	(Year) 281	b. Time of Injury	28c. Injury Work		28d. Describe I				
<u>Si</u>	Attending or deeth. ector: After by the fune		2 ☐ Accident investigation			N		res 2□No					
Division	tal or Attending P rs after deeth. al Director: After t ed in by the funer		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.		, farm, street, f	factory, office		28f. Location (S City or Tox		n <i>ber or Rura</i>	l Route Num	ber,
Q	ral D												
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	BOICE	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	sician: To the best of iner: On the basis of and manner stat	examination	dge, death occi and/or investig	urred at the tim gation, in my op	e, date and place, inion, death occur	end due to the red at the time,	cause(s) and r date and place	manner es si e, and due to	tated. the cause(s)
	withir comp	Σ	29b. Signature and title of certifier				29c. License	number		29d. Date sign	ned (Month,	Day, Year)	
	RD,		and rohin	DR- USH	A N4	risan	Dos	7359		June:	7/5 2	006	
	1/2		30. Name and address of person who	completed cause of de	eth (Item 23	a) (Type, Print))	· ·					
_	//		DR-USHA NATI				57 50	AUSBUR	y 70:	1804			
	State	•	31. Date filed (Month, Day, Year)	32. gistra	r's Signature					4,7			

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Beverly Ann Stanley Certificate of Death 1- For State Registrar Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ June 4, 2006 2038 hrs Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number Dorchester Dorchester General Hospital Cambridge 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) **Funeral** oreign Hours Director Coun 2 / F M Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10b. County Yes 2 No or 28a-f show notified at once Director 10g. Citizen of What Country? 10e. Street and Numbe tes I and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. 0 23a Funeral Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black or items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 V No Yes f Yes, Give Year 1 Yes 2 No Divorced Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) event, the Medical Baltimore, MD 21215-0036 SSembly Rehab. Line 17 Father's Name (First, Middle, Last) tem 27 is marked traumatic event. t Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mailing Address nt; If item 27 is other traumat inkwood 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date / crematory or other place) 1 Burial Removal from State Pages 1 2 Cremation Pleasant Cemetery Saleni. Mary Donation 5 Other Specify 21. Signature of Funeral Service Licensee Henry 510 Wa FUNERal hington Cambri MD. 216 Approximate Interval Between Onset and 23a Part/L Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** e. List only one cause on each line /Medical Death a Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Deep Venous Thrombosis of Lower Extremity Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED UNPENDED burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE the attending phy: ed for use as the b 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 V Unknown be detached 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No within 24 hours after www.

To the Funeral Director; After this centure.

To the Funeral director; of the funeral director. 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: Natural Yes 2 Pendina Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) Suicide determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License numbe 29d Date signed (Month, Day, Year) 29b Signature and title of certifie

State Registrar Assistant Medical Examiner 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

ear)

ORIGINAL

O.C.M.E

111 Penn Street, Baltimore, MD 21201

June 5, 2006

			_ FOI	artment of Health and Mer		ne No. 2006	19631
	Physic	rian	Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
	/Med		Nicholas Solomin		une 12,		12:05 P M
	Exam	iner		4b. City, Town, or Location of Death Bethesda		4c. County of Death	
	Funera		Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. o	Date of Birth	Montgomer 9. Birth	place (State or Foreign ntry)
H	Directo		152-24-4318	Months Days Hours Min.	eb. 18,	1913 Ru	ssia
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	faryla sho	5		vy Chase			1 ∑Yes 2 ☐ No
	the N	rect	Maryland Montgomery Che	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	3a or	Funeral Director	3317 W. Coquelin Terrace	20815		U.S.A.	•
	death me 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No-	14. Race - Ameri Black, White,	
9	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "natural, or items 23e or 28e-f show mastic event, the Mastical Exeminer must be multiled at	교	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2X No Specify:	un, 0.0.,	Consider	
21215-0036	hours tural',	yd by	1 3 KL) Wildowed 4 ∐ Divorced Year or Dates:	adent's Usual Occupation	166	. Kind of Business/Ir	nite
5	in 72	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)	100	, Killa of Dasinessyll	loustry
212	d with	E	Elementary/Secondary (0-12) College (1-4or 5+) 5 S	enior Editor	US	S Informat	ion Agency
פ	al Hyg	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	*	ten Sumame)	
<u>X</u> a	should bind marked	10	Alexandrer Solomin	Unavailal			
	s 1 and 2 should of Heelth and Men item 27 ie merke other traumetic			ling Address (Street and Number or Rural Re			
e,	1 and Heelth		0 = 2 = 11.	W. Coquelin Terr. C		Location - City or T	
Baltimore,	Pages nent of I ant: If its ury or o		LATOURIAL 2 Cremation 3 Hemoval noin State	amatory or other place) June 1	5,	Wash., D.	
	permit. Pages Department of Important: If is any Injury or o			ek Cemetery 200 22. Name and Address of Facility DeVol			
B	Den Timp			222 Wisconsin Ave.,			20007
			23a. Part. Enter the disease, or complications that caused the death. Do not en Mock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	spiratory arrest,		Approximate Interval Between
ä	Physician		Im ediate Cause (Final disaase or condition a Sudden Death				Onset and Death
1	/Medica Examine	•	resulting in death) Due to (or as a consequence of):				
	LXUIIIII	•	Sequentially list conditions, b. Chronic Atrial F	ibrillation			
7	nsit	Examiner	If any, beaching to immediate cause. Enter Underlying Cause (Disease or injury				
Ac.	te be executed ysician end burial-transit	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
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89	Attending Physician: The law requires that the death certificate be execute rideath. rideath. ector: Atter this certificate has been signed by the attanding physician end by the attanding physician end by the attanding by sician end.	() Ean/Med	IF FEMALE:				
80	attand for us		23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
o	the de	hys/c		Other (specify)			
۵.	thet the	10	Part If Other significant conditions contributing to death but not resulting in the	underlying cause given in Part f.	23e. Did tobacc	o use contribute to t	he cause of death?
rds	w requires their been signed to should be de	~ •			1 🗆 Yes	2 X No 3 ☐ Prof	babiy 4 ∏Unknown
000	s bee	Completed			24a. Was an	24b. Were auto	opsy findings available
Ä	The lay	_ E			autopsy performed 1 ☐ Yes 2 🔀	? death?	mpletion of cause of 2□ No
<u>ita</u>	ician: Th certificate		25. Was case referred to medical	26. Place of Death (C	heck only one)		
7	Physician this certifi al di ctor	10	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie				(y)
ב	ding Ph I. After th fureral	lo	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury 20 Accident investigation		. Describe how in	njury occurred	
Division of Vital Records, P.O. Box	I or Attending after death. Director: Aft	3	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, farm, s		Location (Street	and Number or Run	al Route Number.
<u>></u>	하를등	Certification:	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, St		
	To the Hospital within 24 hours a To the Funeral I	Salo	28s Certifier IIX Certifying Physicism: To the best of my knowledge dea	ith pecurred at the time, date and place, and	due to the eause	(s) and mainler as s	hated.
	To the Hos within 24 hc To the Fun cympletely	9 6	one) and manner stated.				
	o time o	5 ≥	29b. Signature and title of certifier	29c. License number	7	Date signed (Month,	
•	1	>	velle 4 1/m y	- 10 ///	/ Ju	ne 12, 20	06
	5		30. Name and address of person who completed cause of death (Item 23 (Type Allen Nimetz, M.D. 5530 Wiscon	o Print) nsin Ave. Chevy Chase	e. MD 20	815	
	9	state	31. Date filed (Month, Day, Year) 32. Registrar's Signature	miles successive states	,		
	Regi		there are a second seco	1-1-			
DH	MH 17 Rev	1/2001	7-3-00- 30- 7	pri			
			ORIG	MINAL			

		1 - For State Registrar	St	ate of N	Marylan		artment of tificate of				iene _{eg. No} .2	06	19632
		1. Decedent's Name (First, Mi	ddle, Last)						1	2. Date of Deal Month	th Day	Year	3. Time of Death
Phys	ician dical	Marti	Evel	yn	San	nsbur	У			June 1	, Ž006	5	8:29 p M
1	niner	A # 100 A1 (11 A 1 A1A)	tion, give stree	t and numbe	r)		4b. City, Town,	or Location	of Death		4c. Coun	ty of Death	
		Anne Arundel	Medica	l Cent	er		Annapo				Anne	Arun	
Funer	al	5. Social Security Number	6. Sex 1 ☐ M			last birthday)	If Under 1 Yea Months Days		Min.	 Date of Birth (Month, Day) 	Year)		place (State or Foreign ntry)
Directo	or	217–56–2917		-X-	90	Yrs.		i	1	Nov. 12	,1915	Mar	yland
and **		Usual Residence of Decedent 10a. State 10b. Cou			10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
Aaryi f eho	1	MD Anne	Arunde	.1		Dunk	irk						1 ☐ Yes 2 🛱 No
28a-	Director	10e. Street and Number	THE CITAL		_	- Dail	10f. Zip Code	5		1	0g. Citizen of	f What Cour	ntry?
with 3a or	2	14 Jewell	Road					20754			U.S	5.A.	
1215-0036 within 72 hours after death with the Maryland ene. I than "naturat", or Items 23a or 28a-f ehow the Madical Examiner must be notilised at	Figure	11. Marital Status	12. V	Was Deceder	nt Ever in U.	.S. 13.	Was Decedent of f Yes, specify Cu		rigin? (Spec	rify Yes or No-		ace - Americ	
or Reco	ă	1 Never Married 2		Armed Forces Yes 2 7 Yes, Give						ican, etc.)		ack, White,	etc.
21215-0036 ad within 72 hours aff giene. er then "naturet", or et, the Medical Exami	3	3 Widowed 4 □ Divor	ced	rear or Dates	5 :		1⊡Yes 2 X No	o Specify:	' :		Spec	"y: whi	ite
5-0 72 hg	Completed	15. Dece (Specify only his	dent's Education			16a. Dece (Give	dent's Usual Occi kind of work don DO NOT use retir	upation e during mos	st of working	g	16b. Kind of	Business/In	dustry
Man of the	100	Elementary/Secondary (0-1		College (1-4o	r 5+)						II G I		. Commission
Pagior at the state of the stat	2		do (not)				Postmast		or's Name	(First, Middle, I			l Service
be fill Hall	å	17. Father's Name (First, Mide	IIe, Last)	λr	schut	7			ydia	(riist, Middie, i	Walueri Surra		inson
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturat", or Nems 23a or 28a-1 show any injury or other traumetic event, the Madical Examinar must be notified at	F		anabia (Tima I		ischut		ng Address (Stree	1		Pouts Mumbo	City or Tour		
Mar 12 st h and 7 le m		19a. Informant's Name/Relati			or		Kurtz A				21122		0 0000)
e, P		20a. Method of Disposition	eurry,	uaugin					Da	The same of the sa	20c. Location		own State
Baltimore, permit. Pages 1 a Department of Her Important: If Item		1 □ Burial 2 Cremati		val from Stat	I U		sition (Name of natory or other pi	1					
ti. Pa		4 Donation 5 Othe			Met		tan Crer			12-06 I	Alexand	dria,	VA
Bal Demi	Duce	21. Signature of Funeral Serv	S CO CIL BUSGO	67					•	D 7	Orzina	· MT	20726
		23a. Part1. Enter the disease	or complication	ons that caus	ed the deat		ausch Fu					JS, ML	Approximate
		shock, or heart failure. Immediate Cause (Final	List only one ca	ause on each	line.					ophanis, an	,		Interval Between Opset and Death
Pnysicia /Medic		disease or condition resulting in death)	a	/Ke/		-	CARC	-INEF	7/9				6 MONTHS.
Examin	_			Due to (or a	as a conseq	uence or);							
	1	Sequentially list conditions, if any, leading to immediate	b. —	Due to (or a	as a conseq	aence of).						-	
uted	Fyaminay	cause. Enter Underlying Cause (Disease or injury that initiated events	1									- 5	
O, exec an an rial-tr		resulting in death) Last	G	Due to (or a	as a conseq	uence of):	-						
18760, icate be executed physicien and s the burial-transit	6	5	d										
68 Hiffica ng ph as tr													
Box 68 Meath certific entitle of a standing place and a standing place	500	23b. Was decedent pregnant		f yes, outcon 1□Live birth			Ectopic pregnan	ю				ate of delive	ery Day Year
O. E. e. e. dea he att	-	in the past 12 months?		4□Pregnant 9□ Unknown		leath 5	Other (specify)	-				normi	Day 16ai
I Records, P.O. Box 68 The law requires that the death certific ate has been signed by the attending plage 2 should be detached for use as t	My cololoyd	9 🗆 Unknown	dialogo contribu		. h.utt	ultina in the	- d- d d	our in Dani		22a Did to	ha asa usa aa	atributa to t	he cause of death?
Signe bed	Ì	Part II. Other significant con	unions control	uting to deati	i Dut not res	aking in ine a	ndenying cause g	given in ran	1.		es 2 No		bably 4 Unknown
w require been signatured by	1											3 1 100	Sabiy 4 Gorianown
Aec law has b	1	<u> </u>								24a. Was a autops	Sy .	prior to co	opsy findings available empletion of cause of
The I		8	-de-							perform 1 Yes	2 No	death?	2 □ No
of Vital Physician: T rthis certificat ral director, pa	á	a examiner?	tical	ital: V			10		e of Death	(Check only on	10)		
of Physical this call dir	F		la app	8a. Date of Ir		ER/Outpatier	it 3 DOA	0.00	-	e 5 Reside			fy)
Sing ling	2	1 Natural 5 □ Pe	nding	(Month, l	Day Year)	28b. Time o Injury	W	ork? □ Yes 2 □		8d. Describe h	ow injury occi	alled	
Attending r death.		2 Accident inv 3 Suicide 6 Co	estigation uld not be	Re Place of	Iniury - At h	ome farm str	eet, factory, offic		-	8f. Location (S	treet and Nun	nber or Rura	al Route Number.
Division of Vital Records, to attending Physician: The law requires to effect death. Director: Alter this certificate has been signed in by the funeral director, page 2 should be con his by the funeral director, page 2 should be continued.		4 ☐ Homicide de	termined 2	building,	etc. (Specif	y)	cot, factory, offic	•	-	City or Town			ar reducertamber,
Hospital 14 hours Funeral I	2		itying Physicia	n: To the be	st of my kno	wiedge, deat	h occurred at the	time, date a	ind place, ar	nd due to the c	ause(s) and r	nanner as s	tated.
_ (\ _ 0		29a. Certifier 1 M Cert (Check only 2 Med	cal Exeminer:	On the basis and manner	of examina	ition and/or in	vestigation, in my	opinion, dea	ath occurre	d at the time, d	ate and place	e, and due to	o the cause(s)
To the within To the comple		≥ 29b. Signature and title of ce	tifier	al.	1 .	/	-	nse number		2	9d. Date sign	ed (Month,	Pay. Year)
		Marvey	11	leins	kld		10	515	8		06/	02/	2006
		30. Name and address of per	son who compl	eted cause o	f death (Iter	n 23a) (Type,	Print)						
12		Harvey J. St	einfeld	d, M.D	., 613	31 Shad	dy Side :	Rd., S	Shady	Side, 1	MD 20	764	
	State	31. Date filed (Month, Day, Y	ear)	32. Regi	strans Signa	ature	Sporte		-				
Reg	istra	r U	אוע - 6	Zhnp >	DIMEN	4 S.	Sparke	5					

amend item 5 per flag 869 10-23-06 Wealth and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 5 [□]2006 Year JAMES BROWN STEVENS 14:20P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Oeath Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Yrs. Director 214-32-3144 73 10/06/1932 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Exactings must be notified at OUEEN ANNE's Director MD CHESTERTOWN 1 Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2207 McGINNIS ROAD 238 21620 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ty∏Yes 2 ☐ No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 COMMUNICATIONS LABORER other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mentel ie marked FREDRICK CLAYTON STEVENS MARY CLARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i JOHN A. STEVENS?BROTHER 2207 McGINNIS ROAD CHESTERTOWN MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H important: if its eny injury or of once. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CRUMPTON CEMETERY 6/9/2006 CRUMPTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS HELFENBEIN & NEWNAM FUNERAL HOUSE ST. MILLINGTON MD 21651 23a. Jant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stellans Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer of the Lung **Physician** Oat month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine physicien end s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Oid tobacco use contribute to the cause of death? Division of Vital Records. COPD/CAD 1. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available pnor to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 240 No certificete 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ☐ ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification; 28d. Describe how injury occurred 10 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours efter To the Funeral Dire To the Hospital Actifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0050996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leil Stockdard St. MD 31. Date filed (Month, Day, Year) 32. Register's Signature State 8 2006 JUN -Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JAMES W. SLATTERY JUNE **Physician** 2006 |18:54 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/01/1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 XM 2□ F 222-12-7021 76 Yrs. DE Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at MD 1 Yes 2 No CECIL Director EARLEVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 WALNUT STREET 21919 USA Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) during most of working Coltege (1-4or 5+) Elementary/Secondary (0-12) DRYWALL FINISHER CONSTRUCTION permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Importent: If Item 27 Is marked other tt eny injury or other traumatic event, Illia 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THOMAS SLATTERY OLIVE COLLINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TIMOTHY SLATTERY/SON 20 CHARRING LANE, NEW CASTLE, DE 19720 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06/09/2006 WILMINGTON, DE ALL SAINTS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME 130 SPEER ROAD, CHESTERTOWN, MD 21620 word sellows Approximate tntervat Between Onset and Death 23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final **Physician** ulmona disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 □ Yes 2 10 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No ernoton 2010 1 ☐ Yes 25. Was case referred to examiner? Be line 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Lapatient Certification: To 1 Yes 2010 2 ER/Outpatient 3 DOA After th 27. Manney Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Unaturat 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation tor: 6 Could not be determined within 24 hours after dea To the Funerel Directo completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ro the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Morns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) re, Chastatown 415 Wash MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

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			Decedent's Name (First, Mid	dle, Last)							2. Date of De	ath		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not instituti			<u> </u>		4b. City, Tow	n, or Location	of Death			County of De	
	Examin	-1	DEERS HEAD HO	SPITAL C	ENTER			SAL	ISBURY				WICOM	.co
	Funeral		5. Social Security Number 775	8 6. Sex	7. Ag		last birthday)	If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Bir (Month, Da	th V Year)	9. B	inthplace (State or Foreign Country)
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	ter de	Š	1 Never Married 2 Mi	Arm	ed Forces? Yes 2 🗀			ff Yes, specify (Cuban, Mexica	an, Puerto	ecify Yes or No Rican, etc.)		Black, Wh	
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#25
AMEND#26,28C Per Fitate of Maryland / Department of Health and Mental Hygiene For AMEND#26,28C FET FIT State Registrar 6/5/06 AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 05 Year 1920 M J. Thompson **Physician** Edward 30 3004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne GlenBurnie Arunde BWMC Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□ F Yrs. Maryland 24, 1918 Director -212-16-3401 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It has a 23s or 28s-1 show item 27 is marked other than "natural", or theme 23s or 28s-1 show other traumatic earwell, it a Medical Examiner must be notified at other traumatic earwell, it a Medical Examiner must be notified at 1 ☐ Yes 2X No Severna Park MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 USA 715 Benfield Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, Whife, etc. 1 □ Yes 2 No ff Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White 1 ☐ Yes 2 ☑ No Specify: Specify: Baltimore, Maryland 21215-0036 Completed by Thompso 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transit Casualty Co. Attorney 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daisy Slaughter Henry Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Severna Park, MD 21146 715 Benfield Road Elsie H. Thompson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) June 3, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Park Elkridge, MD 2006 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov.Ritchie Hwy. 21. Signature of Fun ral Service Licenses P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Befween Onset and Death ARRE CARDIAC fmmediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 Fetal death Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA မ this nerel Director: After the filled in by the funeral 28c. Injury af Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 ☐ Yes 2 1 No death. investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie H0052510 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 202 W. Maple Rd 26+36 Linthicum MD 21090 raig 32. Raisfrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

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					State	of Marylai		artment of I rtificate of	Death		glerie Reg. No.	16	19637
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	3a or 28a		10e. Street end Nu 701 Glenv	umber Vood Sti	eet		_	10f. Zip Code 21401			10g. Citizen of W United	hat Cour Stat	ntry? es
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D	Hyg other ent,	Se L	17. Father's Name	(First, Middle, I	Last)				18. Mother's Na	me (First, Middle	, Maiden Sumame	e)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Trott June 2006 0058 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Aug. 15,1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 62 Yrs. 218-42-9971 Director Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Itame 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 715 Bay Ridge Avenue 21403 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2XXMarried 1 ☐ Yes 2XXVo White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary MD Environmental Agcy permit. Pages 1 and 2 should be file Depurtment of Heelth and Mental Hy Important: If item 27 is marked othe any njury or other traumatic event, 0000 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Robert W. Ogle Laura Jacobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis D. Trott (Husband) 715 Bay Ridge Avenue, Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2XX remation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 6-5-2006 Baltimore, MD 21. Signature of Funeral Service 0 Hardesty Funeral Home, P.A. 70 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Subarachnoid Physician Hemonhage 2 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner cate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Physicien: The law requires that the death certificate be executed Obstructive & Restrictive Lung Duease Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ yphoscolosis 3 Probably 4 □Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? Yes 2/X No 1 Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Apatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funerel Direct 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

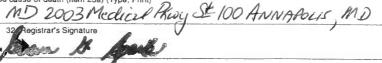
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar 31. Date filed (Month, Day, Year) JUN 0 6 2006

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

ANDREW GORDON



Division of Vital Records, P.O. Box 68760

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** GEORGE G. TILL 1156 5 2006 une /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Easten Hospital Talbot The Memorial 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1**★**M 2□ F 140-22-0767 JAN 28, 1929 **NEW JERSEY** Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1XYes 2 ☐ No Director BUCKS PA NEW HOPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2405 NORTH RIVER ROAD 18938 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE ρ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BANKING VICE PRESIDENT-BANK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DENNIS TILL IDA MAE SICKNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE TILL/WIFE 2405 NORTH RIVER ROAD, NEW HOPE, PA 18938 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I important: if its any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State FRANKLIN MEMORIAL PARK 6/10/2006 NORTH BRUNSWICK, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 JOHN Z. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due o (or as a consequence of): Examiner Willmonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, signed by the attending physician abe detached for use as the buria Country at hy Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ours after death. naral Director: After this certificate has been si filled in by the funeral director, page 2 should I 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature,and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton, M Haider MY 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar JUN 0 6

State of Maryland / Department of Health and Mental Hygiene ? [] [] [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 15 2006 4:20 June Α Turner Marlene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Avalon Manor 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Min. **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. June 17, 1934 Maryland 71 217-28-2107 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County Wode Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

anit if item 27 is marked other than 'natural', or items 23a or 28a-f show anit if item 20 is marked other than "hatural", or items 23a or 28a-f show any or other traumatic event, it is Maddell Examinat that call withing at 1 X Yes 2 No Director Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21740 U.S.A. 11 W. Baltimore St. Apt. 301 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook Food Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Violet Drury Jetson Upton Pryor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steve W. Turner/Son 12800 El Paso Dr., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition tment of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of transportants if any injury or gode. 6/19/2006 * 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mark 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or comparations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metan Cancicoma fer moth Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, Palm churchen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Natising Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Ho 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural after death.

Director: Aff 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide within 24 hours a
To the Funeral C
completely filled Hospital 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D (8019 JUNE 15, 200 6 -contino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 21748 MILLST MAGERSTOWN MD VASANT DATTA MD 32 Segistrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 1 2006 Registrar

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	3/4	*5, * ·	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day	Year	3. Time of	Death
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de se	/Medic Examin		4a. Facility Name (If not institution, give stree			4b. City, Town, or	Location of Death		4c. Cou	inty of Death		
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	Funeral		Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1		lace (State o	r Foreign
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an	Mental Merked o	To Be	John Rashberry Some	rville			Alice (Cecelia	Brooks	3		
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Ital M	Ě	19a. Informant's Name/Relationship (Type,		19b. Maili	ng Address (Street a	and Number or Ru	rai Route Numbe	r, City or To	wn, State, Zip	Code) 20	653
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lo I	00		1 X Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	-	of Peace	4	-2006	Hele	n, Mar	vland	
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			James Boyd, 234)			d, Califo	rnia, MD	20619				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE 2006 2:15 EDITH VIOLA WATERS TAYLOR /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RESIDENCE. 7821 BUMPY OAK ROAD CHARLES LA PLATA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. JANUARY 31, 1915

9. Birthplace (State Country)

MARYLAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Yrs. 217-30-0471 91 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director **CHARLES** MARYLAND LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heelih and Mental Hygiene. Important: If item 27 is marked other then."—
any njury or other trainment. 7821 BUMPY OAK ROAD 20646 UNITED STATES Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Etementary/Secondary (0-12) Colfege (1-4or 5+) 11TH GRADE HOMEMAKER HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS WATERS MARY ALICE BLAIR WATERS ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SADONIA TAYLOR / DAUGHTER 2718 ADELPHI LANE, BRYANS ROAD, MARYLAND 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ST. JOSEPH'S CHURCH CEMETERY JUNE 12,2006 POMFRET, MARYLAND 21. Signation of Funeral Service Lious THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 TERRENCE L. JOHNSON M00993 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIOPULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner VALVULAR HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed SEVERE KYPHOSIS Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. signed be del Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by HYPERTENSION 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No of Vital 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ၉ 28c. Injury at Work? 27. Manner of Death 1 A Natural Certification: 28b. Time of 28d. Describe how injury occurred Hospital or Attending Division Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation in 24 hour.
the Funstal Dirac. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD20545 JUNE 7, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 IRVING STREET, N.W., SUITE 409 WASHINGTON, D.C. 20010 FITZGERALD BIRMINGHAM, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2006 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Ellen Rebecca Tilley Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1814 hrs Ellen Rebecca June 4, 2006 Medical Examiner Tilley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's I-495 south of Ritchie Marlboro Road Capitol Heights B. Date of 8irth (MM/DD/YYYY) 9 Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Davs Hours Months Director 30.1940 ountry) Maryland 65 August 1 M 215-38-337 Usual Residence of Deceden 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 XNo MDCharles La Plata 28a-f show Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5630 Hilltop Road 20646 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes White If Yes, Give Year 1 Yes 2 X No specify Specify: Widowed Divorced ⋧ Decedent's Usual Occupation (Give kind of work done 16b Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DD NDT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 h and Mental Hygiene permit Pages I and 2 should be filed within 7.
Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other tranmatic access. MD 21215-0036 Secretary Food Store 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Harvey James Stine, Sr. <u>Ann Stine</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pand 5630 Hilltop Road 20b. Place of Disposition (Name of cemetery, Date Glenwood Tilley, Jr. / Husband La Plata MD 20646
te | 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Surial 2 Cremation 3 Removal from State Clinton,Maryland Resurrection Cem. 6/9/06 Donation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility M00945 AREHART-ECHOLS FUNERAL HOME, P.A. 20646 Echo Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Mad is Yardisc or Asyletory artist shock Loanzact. MILApproximate Interval **Physician** failure. List only one cause on each line. /Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): and - transit requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** attending physician : burial Box 68760, IF FEMALE. 23d Date of delivery 23c. If yes, outcome of pregnancy the Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Dther (Specify) Yes 2 V No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ Records, P. Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? No ✓ Yes 2 1 🗸 Yes 26. Place of Death (Check only one) 25 Was case referred to medical of Vital Be examiner? Dther₄ Inpatient 2 ER/Dutpatient 3 DDA Nursing Home 5 Residence 6 🗸 Dther: Scene this 1 V Yes No 28a. Date of Injury (Month, Day, Year) Jun 4, 2006 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Driver of auto involved in collision 1805 hrs Natural Yes 2 V No Pending the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide Interstate 495 @ Richie Marlboro Road, Capital 24 hours a (Specify) Major Road / Highway Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of O.C.M.E June 5, 2006 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD.

DHMH 17 Rev 1/2001 **DCME 2006**

State

Registrar

31. Date filed (Month, Day, Year

0

JUN

200€ 8

strar's Signature

06-04181 Ashley Tucker

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Cert	ificate of Death		Reg. No.	0 704
Physician/	Decedent's Name (First, Middle,I			2. Date of Month	Day Year	3. Time of Death
ledical Examine	1-011107 11100		1 a =	June 1	6, 2006	1757 hrs
	4a. Facility Name (if not institution, Union Hospital		Elkton	Location of Death	4c. County of Death	
Funeral	Social Security Number 6	. Sex 7. Age (In yrs. las	st birthday) If Under 1 Year Months Day	e House Min	of Birth(MM/DD/YYYY) 9. Bir Foreig	an .
Director	215-29-0690	1 M 2 X F 16	Yrs.	June	4, 1990	ountry) MD
>-	Usual Residence of Decedent 10a. State 10b. County	100 City 1	Town or Location			10d. Inside City Limits
w any	MD Cecil		clestown			1 X Yes 2 No
Aaryland 28a-f show 1 at once. ector	10e. Street and Number		10f, Zip Code		10g. Citizen of What Cou	
the Maryland a or 28a-f sh iffied at once	345 Caroline S	Street	219	21.4	U.S.A.	ind y :
23a c		12. Was Decedent Ever in U.S		spanic Origin? (Specify Yes o		ican Indian, Black,
or items 23	1 Never Married 2 Marr	ied Armed Forces?		n, Mexican, Puerto Rican, etc.		
iter de I", or er mu		1 Yes 2 X No	1 Yes 2X No	specify:	Specify: Whi	te
atural"	15. Decedent's Education (Specif	or Dates: y only highest grade completed)	16a. Decedent's Usual Occupa during most of working life		16b. Kind of Business/	Industry
6 72 hours an "natur cal Exam	Elementary/Secondary (0-12)	College (1-4 or 5+)		. DO NOT use retired/	77' 1 0 1	7
15-0036 Iled within 72 Hygiene. In other than the Medical	10		Student	18.Mother's Name (First, Mide	High Sch	JOOT
filed of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other of the other other of the	Paul F Tuck			Tina Brewster	,	
b 21214 should be fill and Mental F 7 is marked natic event, 1			19b. Mailing Address (Stree	et and Number or Rural Route		e, Zip Code)
nore, MD 2 gges 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic	Susan Tucker (S	Step-mother)	345 Caroline	e St., Charle	stown, MD 21	914
e, MC 1 and 2 st Health an Titem 27 ir trauma	20a. Method of Disposition		lace of Disposition (Name of ce ematory or other place)	metery, Date	20c. Location - City or	Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Heath and Mental Hygiewie. Intel 1 item 27 is marked other than "natural", or items 23a or 28a-f she unit. If item 27 is marked other than "natural", or items 20 or 28a-f she unit. If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 X Burial 2 Cremation 4 Donation 5 Other Spe	Har	ford Mem. Gdns	6/23/06	Aberdeen,	Maryland
Baltimore, MC pemit Pages and 2 s Department of Health at Important: If item 27 injury or other traum	21. Signature of Funeral Service Li	censee	22. Name and Address	of Facility uneral H	ome.P.A.	
@ 88 E :	Rusten House	Milespel	Aberdeen,	Maryland 210	01-3399	
Physician /Medical	23a. Part I. Enter the disease, ∮ r co failure. List only one cause of				y arrest, shock, or heart	Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Head injury compo		152		Death
, Tab		b.				
Jac	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of)):			70
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of)):			
		d				
al al	X UNPENDED	AMENDED item#23a,2	27,28a-f,perME,g85	6,6/22/06 TT		
	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn			23d. Date of deliver	•
68 certifi		1 Live birth Pregnant at time of dea	2 Fetal death 3 ath 5 Other (Specify)	Ectopic pregnancy	Month	Day Year
Box 68 e death certi the attending ed for use as	1 Yes 2 No 9 🗸 Unkn	own 9 Unknown	Other (Opeciny)			
, P.O. Box 68' rres that the death certifi signed by the attending be detached for use as in	L Part II. Other significant conditio	ons contributing to death but not re-	sulting in the underlying cause	3.1-11.11.	Did tobacco use contribute to	
s, P.C					Yes 2 No 3 Pro	
(ecords, he law requires are has been signage 2 should be					autopsy prior to	utopsy findings available completion of cause of
Recol The law icate has page 2 s	5				performed? death? Yes 2 No 1 ✓ Y	es 2 No
Vital Rec ysician: The his certificate director, page			26.Plac	e of Death (Check only one)		
	aveminer?	Hospital:	ER/Outpatient 3 DOA	Other Nursing Home 5	Residence 6 Othe	r:
Vita hysici this c	1 Yes 2 No			10015		
of Vitaling Physici After this c funeral direction To F	1 Yes 2 No	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Inju	<u> </u>	ribe how injury occurred	
Sion of Vit. Attending Physici death. Ector: After this c by the funeral direc	1 Yes 2 No	28a. Date of Injury (Month, Day, Year) 6/16/2006	28b. Time of Injury 28c. Injury 1	Yes 2 X No subje	ct_fell in well	ural Poute Number City
Division of Vital Records, P.O. Box 68 at or Attending Physician: The law requires that the death certificate has been signed by the attending of in by the funeral director, age 2 should be detached for use as defin by the funeral director, page 2 should be detached for use as diffication: To Re Commission the Noticinian	1 Yes 2 No	28a. Date of Injury (Month, Day, Year) 6/16/2006 28e. Place of Injury - At ho	28b. Time of Injury 28c. Injury Fnd 2:50 pm 1 me, farm, street, factory, office	Yes 2 X No subje	ct_fell in well	ural Route Number, City ine St.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1 Decedent's Name (First, Middle, Last) Dey 2006 Month **Physician** 15, June Earl M. Trice 12:45 PM /Medical 4b. City, Town, or Locetion of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Allegany Cumberland Devlin Manor Health Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Yeer) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 ☐ F Yrs. 1930 Pennslyvania 171-26-0932 Aug 17 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mentel Hygiene.
Int: if Item 27 is marked other than "natural; or items 23s or 28s-f show Lry or other traumetic event, The Medical Experient mast be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Frostburg MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21532 USA 16511 Harwood Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 <u>۾</u> 3 Widowed 4 Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Steel Mills Labor 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Be Edna (Poole) Trice John Trice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health e important: if item 27 is any injury or other tra 16511 Harwood Drive, Frostburg, MD 21532 Wife June (Fry) Trice 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silbaugh Crematory 06/16/06 Uniontown, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hafer Funeral Service, 1302 National Hwy., LaVale, MD 21502 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) OPD Examiner Physician/Medical Examiner ettending physician end I for use es the buriel-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Division of Vital Records, P.O. Box 68760 that initiated events Due to (or as a consequence of) resulting in death) Last ed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should be det à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No eral Director: After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled 🗠 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number m 15, 2006 D0017565

State Registrar

31. Date filed (Month, Day, Year)

AJBOllino

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)



Labria

			1 - For State Registrar		State of	Marylar	nd / Depa			lealth a	and M	ental Hy	giene Reg. No.	211111	19	546
	Physici	an	Decedent's Name (First, Middle	, Last)								2. Date of De Month	ath Day	Year	3. Time o	Death
	/Medic		Blanca Nieves									June	5	2006	5:30) <u>A</u>
	Examin	ier	4a. Fecility Name (If not institution	, give sti	reet and num	iber)		4b. City	, Town, or	Location of	of Death		4c.	County of Dea	ath	
			Holy Cross Hos 5. Social Security Number	pita 6.Sex		7 Age (In vrs	. last birthday)		r 1 Year	Sprin		8. Date of Bi	th]	Montgor	nery nthplace (State of	or Foreign
	Funeral Director				M 2⊠F	7.8		Months		Hours	Min.	(Month, Da	ay, Year)		ountry)	n r oreign
			578-84-0157 Usual Residence of Decedent							J		Aug. 5	,192	/l	ıba	
	nylan how	_	10a. State 10b. County			10c. C	ity, Town or Lo	ocation							10d. Inside C	•
	Ba-f e	cto	Maryland Montg	omer	у		Silver									2 € No
	vith th		10e. Street and Number					10f. Zi	p Code				10g. Citi	zen of What C	ountry?	
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	ter de Item	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marr		Armed For	ces?	3.5.	If Yes, spe	cify Cuba	in, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	,	Black, Wh		
336	urs af	by	3 ∰Widowed 4 □ Divorced		If Yes, Give Year or Da	9		1 X Yes	2□ No	Specify:	Cub	an		Specify:	ack	
Ö	2 hou	Completed	15. Decedent	's Educa	ation		16a. Dece	dent's Usu	al Occup	ation during mos			16b. Ki	nd of Busines		
215	thin 7	pie	(Specify only highes Elementary/Secondary (0-12)	i grade	College (1-	4or 5+)	life.	DO NOT	ise retired	during mos I)	t or worki	ng				
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gu	be fill d oth	Be	17. Father's Name (First, Middle,							18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
Maryland 21215-0036	Jould J. Mer. narks	2	Jose Antonio T	-			10h Maili		- /Ctt		men	Ama		r Town, State,	7i- C-d-l	
Mai	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23a or 28a-1 show other traumatic event, ite Medical Evantical must be notified at		19a. Informant's Name/Relations					1000-00								
	is 1 and 2. If Health a litem 27 is other trace		Marie F. Portu- 20a. Method of Disposition	ondo	Dau	ighter 20b.	1611 Place of Dispo	sition /Na	me of		51	Iver S	20c. Lo	Mary 1	r Town, State	1903
nor	ages nt of t: If it		1 ⊠ Burial 2 ☐ Cremation		moval from S	State Ga	cemetery, create of	_{matory} or Heave	other plac 2 11							
Baltimore,	permit. Pages. Department of H Important: If ite any injury or of		4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service				2:	Name a	etery	ss of Facilit	hv .				ing,Mar	yland
Ba	Dermi Depa Impo any i		(carolina)	Q	(ple		Fr	ancis	iJ.	Colli	ns F	uneral	Home	Inc.	g,MD 20	001
	_		23a. Part1. Enter the disease, or	complic	ations that ca	aused the dea								PDITI	Approxima	te
	Physician		shock, or heart failure. List Immediate Cause (Final	only gne											Interval Be	Death
	/Medical		disease or condition resulting in death)	a.	Resp	oirator orasaconse	y Fail quence of):	ure							6 day	S
	Examiner		Commentative link annulising	ь.	Aspi	ration	Pneum	onia								
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) "	Due to (or as a consu	quence of):									
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	icate be executed physicien and s the burial-transit			d.	_				_							
9 X	death certific e attending p id for use as	Physician/Med	IF FEMALE:	23	c. If yes, outo	come of pregr	nancy							23d. Date of de	aliven	
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rds	w require been sig should b		Cancer of Eso	phag	us							1 🗆	Yes 2[□No 3□F	robably 4 🛣	Unknown
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of Vital Records,	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?							26. Place	of Death	(Check only				
<u>></u>	Z ∞ 5	은	1 ☐ Yes 2 🙀 No	Ho	ospital: 1 🙀 Ir	npatient 2	☐ ER/Outpatie			4 🗆 140	irsing Ho	πe 5□Res	idence (6 □Other (Sp	ecify)	
ū	ing P After t	e E	27. Manner of Death 1 XNatural 5 ☐ Pendin	g	28a. Date o (Monti	of Injury h, Day Year)	28b. Time o		28c. Injun Wor			28d. Describe	how injur	y occurred		
sio	Attending r death.	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could					М		Yes 2 🗌						
Division	or At	Certification:	4 Homicide determ		28e. Place buildin	of Injury - At I ng, etc. (Spec	home, farm, st ify)	reet, facto	ry, office			28f. Location (City or To			Rural Route Num	ıber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 📉 Certifyin	a Physi	cian: To the	hest of my kn	nowledge, deat	h occurre	t at the tim	no date an	d place	and due to the	031100/0/	and manner	s stated	
	24 hd 24 hd Fun etely	edical	(Check only 2 Medical one)	Examin	er: On the ba	isis of examin	ation and/or in	vestigatio	n, in my o	pinion, dea	th occurr	ed at the time,	date and	place, and du	e to the cause(>)
	within 2 To the comple	Me	29b. Signature and title of certifie	г				29	c. Licens	e number			29d. Dat	e signed (Mor	nth, Day, Year)	
	(Strules O.	d	Lunk	13			D 17	260				E 000		
•	4		30. Name and addres of person	who con	npleted cause	e of death (Ite	эті 23а) (Туре,	Print)	D 17	აღგ			lune	5. 200	6	
	1		Stanley A. So	hwa	rtz, M	.D. 2	101 Med	dica1	Par	k Dri	ve	Silver	Spri	no_Mar	vland_2	0902
		ate	31. Date filed (Month, Day, Year)		32.86	egistrar's Sign	nature	ask!	9		-				<i>,</i>	
	Regist	rar	JUN 6	200	סר	Bur.	er pop	-								

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

6 2006

State of Maryland / Department of Health and Mental Hygiene 19668 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2006 1 1643 Andrew Jackson Thompson June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Hospital of Cecil County Elkton Cecil If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F 67 219-34-2310 Sept. 16,1938 Maryland Director Usual Residence of Decedent the Maryland 10c. City Town or Location 10d Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Exertition must be contilled at 1 ☑ Yes 2 ☐ No Charlestown Directo Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21914 ILS.A. 701 Caroline Street itema 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Amed Forces? 1⊈Yes 2□ No If Yes, Give Year or Dates: 1963-67 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aberdeen Proving Ground al Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) Two Years Aberdeen, Maryland Test Director 17 Father's Name (First Middle | ast) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be f Mental H is marked Alice Malinda Bird James W. Thompson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances W. Thompson nt of Health at: If item 27 i (wife) 701 Caroline Street, Charlestown, Maryland other 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or once. West Chester, Pennsylvania R.A. Ferris & Co., Inc. 06/04/06 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. MATTHERODI W Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aguste Myocardial
Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Convers Actory
Due to (or as a co sequence of): Deac if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit while the length Due to r as a consequence of): resulting in death) Last P.O. Box 68760. The law requires that the death certificate be Physician/Medical use as the IF FEMALE 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed I page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Vichotoo Division of Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 1 ☐ Yes 2 XNo this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of tnjury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 25e Cartillar TS Conflying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cauca(e) and manner ac stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and tle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/1/2000 DODIT37. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) garry Tool 111 MHW & Ste 312 m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 2006

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		-	For State	State of Marylar		artment of I <i>tificate of</i>				2006	19649
			Registrar 1. Decedent's Name (First, Middle, L	ast)		tineate or	Death	2. Date of Dea			3. Time of Death
	Physicia /Medic		MARTHA E.	TRADER				Month O6	OI	O6	0740 AM
3	Examin	er	4a. Facility Name (If not institution, ga	ive street and number)	0	·	or Location of Deat	h	4c. (County of Death	
	Europal		ENINSULA KEG 5. Social Security Number 6.	Sex T. Age (In yrs.	last birthday)	SALIS If Under 1 Year			th C	JICAM 9. Birth	
t	Funeral Director		212-72-0608	1□M 20 F 45	Yrs.	Months Days	Hours Min.	(Month, Da	v. Year)	Cou	place (State or Foreign Intry)
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Maryli f eho	jo	1			SBURY	(1 Tes 2 □ No
	or 28s	lrec	10e. Street and Number	^	<u></u>	10f. Zip Code			10g. Citiz	en of What Cou	intry?
	ath will	Funeral Director	201-PRINCETON				804			USA	
	Itams	nne	11. Marital Status 1 Never Married Married	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	ipecify Yes or No to Rican, etc.)	- 1	 Race - Ameri Black, White 	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygione. Ither than "natural", or Items 23s or 28s-f show int, the Medical Examirer must be notified at	þ	3 Widowed 4 Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1□Yes 2★No	Specify:			Specify: B	LACK
2-0	72 ho 'natur dical	Completed	15. Decedent's (Specify only highest g		(Give	dent's Usual Occu kind of work done	during most of wo	rking	16b. Kin	nd of Business/Ir	ndustry BUILDING
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0 0	illed with Hygiene. other ther	Be Co	17. Father's Name (First, Middle, Las	st)	11/30/	SUPE	RVISOR 18. Mother's Nam	me (First, Middle,			AY CARE
<u>lar</u>	should be and Mental marked o	ToB	ARTHUR R.F.	ARLOW			MART	HA E	\perp	UTTO	No
Mar	and and is m	1	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	t and Number or Ri	5) 8	er, City or	Town, State, Zi	p Code)
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Baltimore,	Pages nent of I int: If It		Burial 2 Cremation 3	☐Hemovai from State	cemetery, crei	matory`or other pla M	CH 6/	7/06	DEI		D
a	permit. Page Department of Important: If any Injury of once.		21. Signature of Funeral Service Lic			. Name and Addre	1 404	ENNIE	SIM		Н
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о. О.	the de y the s	Physiclan/M	1 ☐ Yes 2 No 9 ☐ Unknown	4∏Pregnant at time of 9☐Unknown	death 5L	Other (specify) _					
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a F	ilcian: Thi certificate rector, pag		SCLERADERI	4A				1 Tes	200? 200.No	death?	20 No
⋚	ysicia is cert	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 20 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ot	hor	ath <i>Check only o</i> Home 5 ☐ Resid		□Other /Snec	(fv)
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sio	death. ctor: A / the fu	cati	2 Accident investigat 3 Suicide 6 Could not	ho -		M 1	Yes 2 No				
Division of Vital Records,	l or Attano efter deatl Diractor: I in by the	Certification:	4 Homicide determine		home, farm, str eify)	eet, factory, office		28f. Location (3 City or Tox	Street and vn, State)	l Number or Rur	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only 2 Medical Ex	Physician: To the best of my kn aminer: On the basis of examin	nowledge, deat	h occurred at the t	ime, date and place	a, and due to the	cause(s)	and manner as	stated.
	thin 24 thin 24 the F mplete	Medi	one) 29b. Signature and title of certifier	and manner stated.			se number				
	~ V	_	1/1/1/20	" MIT	115	7				signed (Month,	ouy, Icai)
	3.7		30. Name and address of person who	o completed cause of death (Ite	om 23a) (Type,	Print)	006036	•	9/	100	
			M.T. HIMMIARAT	APPA 614	BEA	STERN X	HORE DI	2, SALIS	BUI	ey MI	21804.
j	Sta Registi		31. Date filed (Month, Day, Year)	32. Pegistrar's Sign	d. A	ade!	HARE DI				

TEABER, MARTHA 212-12-0608

		•	For State Registrar	State of I	Maryland / Depa	artment of Hertificate of E		-	giene	06	19650
	Diam'r.		1. Decedent's Name (First, Middle,	, Last)				2. Date of De		Year	3. Time of Death
								MAY	27	2006	9:50PM M
	Examin	er			er)	4b. City, Town, or			4c. Count	y of Death	
					Age (In yrs. last birthday)	If Under 1 Year	STON If Under		rth	TALB(DT blace (State or Foreign
			213-01-8436	6. Sex 1 M 2 F 7.	88 Yrs.	Months Days	Hours	24 Hrs. 8. Date of Bin (Month, Date of May 14)	1918		LAND
	D		Usual Residence of Decedent			<u> </u>					
	show	7			10c. City, Town or Lo					1	0d. Inside City Limits 1 Yes 2 □ No
	tha N	ecto		OT	EA	STON 10f. Zip Code	-		10g. Citizen of	What Cour	
	with 3e or	ΙΩ		TON ST.		21601			rog. Citizeri oi	USA	its y:
	death ms 2	nera	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of His	spanic Ori	gin? (Specify Yes or No	o- 14. Ra	ce - Americ	
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ng	al Hy a othe vent,		17. Father's Name (First, Middle, I	Last)			18. Mothe	er's Name (First, Middle	, Maiden Suma	me)	
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Mar	d 2 sh sh and 7 Is m traum					*		ST., EASTO			Code)
_	Heall tem 2 other		20a. Method of Disposition	DOLI, HILL	20b. Place of Dispo	sition (Name of	1	Date	20c. Location		own, State
Ē	Pages ent of nt: If i				FAIRVIEW	TATORY OF OTHER PLACE		6/3/2006	CORDO	TA. MA	RYLAND
ati	partm porta y inju				22	2. Name and Address	s of Facilit	v			
<u>~</u>	88 28		JOHN R	MER!	ERON 20	JU S. HARE	RISON	BEIN & NEWI ST EASTON	, MD 216	501	IOME PA
			snock, or heart failure. List of	complications that cau only one cause on eac	sed the death. Do not ent h line.	er the mode of dying	, such as	cardiac or respiratory a	irrest,		Approximate Interval Between Onset and Death
Physician / Medical Examiner Funeral Director		disease or condition	-a. Mull	brian 5	V 3 frem	- 6	aifure			My 5	
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		er	if any, leading to immediate	b. Due to (or	as a consequence of):	TUIOSOI	WUJ	[]			years
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	es tha gned be de	by P	Part II. Other significant conditio	ns contributing to deat	h but not resulting in the u	nderlying cause give	n in Part I.			ntribute to th	ne cause of death?
ord	een si	ted	1010	before	MINIPA	1	- V	10	Yes 2 No	3 Prob	ably 4 Unknown
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a			TA	Me do	MINK	disens	1	1 Yes	ormed? 2 No	death?	2□ No
	s certi	o Be	examiner?	Hospital: 1 ☐ Inp	atient 2 ER/Outpatier	nt 3 DOA Other		of Death (Check only or sing Home	on <i>e)</i> idence 6 □Ot	has (0if	
ı of	₽ ₽ B	n; T	27. Manner of Death	28a. Date of			at		how injury occu		y)
joi	endin sath. or: Af	atlo	2 ☐ Accident investig	ation	Day roar) Injury		es 2 🗆	No			
Ĕ	or Att fter de Siract in by t	rtific	d at a ma	ned 286. Place of	Injury - At home, farm, str , etc. (Specify)	eet, factory, office			Street and Num wn, State)	ber or Rura	l Route Number,
	pital		29a Cartifier 1 Territyin	g Physician: To the h	act of my knowledge, don't			d alone and durate the			
	24 hc 24 hc e Fun etely	dica	Check only 2 Medical t	Examiner: On the basi and manner	s of examination and/or in	n occurred at the time vestigation, in my opi	e, date an inion, dea	d place, and due to the th occurred at the time,	date and place	anner as si , and due to	the cause(s)
	within To the compl	Me	29b. Signature and title of certifier	1100 /	9 1	29c. License	number		29d. Date sign	ed (Month,	Day, Year)
			He	110) a	O WID	20	75/	150	5/3	0/0	6
1	(0)						1077	m 01/65	/	/	
	- C1	to.		. 32. Reg		AVE. EAST	LUN,	MD 21601			
	State Registrar 31. Date filed (Month, Day, Year) 3 1 2006										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended#4a, pen _ For MD, TCHD, 05/31/06, sbb Certificate of Dooth 19651 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Examiner **Funeral**

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other treumetic event, the Medical Examinat must be inclined at educa-

Be Completed by Funeral Director

Physician /Medical Examiner

the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medicai Be Completed by To the Hospital or Attending Physician: The law requivitin 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 27. Manner of Death 1 Natural Certification:

EDITH LEE	WATKINS				may	20	200	6 06224
4a. Facility Name (Whot in priviles prive		1	4b. City, Town, o	Location of Death		4c.	County of Dea	th
Memorial	HOSPITO		EAS	DION			alba) [
5. Social Security Number 6. So	ex 7. Age (In yrs. li		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Bir	thplace (State or Foreign ountry)
212-76-0297	44	Yrs.			06-14-	1961	Vir	ginia
Usual Residence of Decedent 10a. State 10b. County	10c Cin	, Town or Loc	nting					10d. Inside City Limits
			ation					1 AYes 2 No
Maryland Talbot 10e. Street and Number	E.	aston	10f. Zip Code			10a Citi	zen of Whal Co	Juntar?
Toe. Street and Number			TOT. ZIP CODE			rog. Citiz	zen or what Co	Junity :
215 W. Dover			216				USA	
11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	 Race - Ame Black, White 	
1 Never Married 2 Married	1 ☐ Yes 2 A No					ŀ		
3 Widowed 4 Divorced	Year or Dates:			эрвену.				ack
		16a. Decede	ent's Usual Occup	ation during most of works	ina	16b. Kir		
Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	a)	J			
11		Cas	shier			F	ood Lic	n
17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	Maiden	Sumame)	
George Cr	aig			Eva	Bell	Watk:	ins	
19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing	Address (Street	and Number or Rura	al Route Numb	er, City or	Town, State,	Zip Code)
Power Ice Watk	ing / Son	215 1	J Dover	Street 1	Facton	Mary	land 21	601
	20b. P	ace of Disposi	ition (Name of					
	Hemoval from State		,	, I	7 2006	Trens		wland
	I.a.				/-2000	Tra	ppe, mar	утапо
1					ral Hom	e MAryi	land 21	601
1		Approximate Interval Between						
	CORONA	RY A	RTERM	DISEAS	=			
	w		C/C	0.00.12	<u> </u>			y car 3
		.,,						
Sequentially list conditions,	b. Due to (or as a consequ	uence of):						
cause. Enter Underlying								
that initiated events	C. Due to for some second							
rosaling in doalin, and	Due to (or as a consequ	dence or):						
	d							
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					2	3d. Date of de	livery
in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)	,		- 1	Month	Day Year
1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown							
Part II. Other significant conditions of	ontributing to death but not resu	ulting in the un-	derlying cause gr	en in Part I	23e. Did t	obacco u	se contribute to	the cause of death?
End Stank	Renal Dist		sony mg occaso gre	on an out it.				.1
2118 01091	· remot Dist				''	res 2L	No 3∏P	robably 4 Ninknown
Hyperten	SION				24a. Was		24b. Were a	utopsy findings available
						rmed?	death?	completion of cause of
05.146					1 Yes	2 No	1 🗆 Yes	2 No
25. Was case referred to medical examiner?	Hospital:		04	26. Place of Death				
1 Yes 2 No	1 Inpatient 2	ER/Outpatient		er: 4 Nursing Ho			Other (Spe	cify)
27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe	how injury	occurred	

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0657067

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

SOOKLAL, 607 DUTCHMAN 31. Date filed (Month, Day, Year)

State Registrar



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

		-	For Stete Registrar	State	of Maryla	and / Dep <i>Ce</i>	artmen ertificat			and Me		iene _{eg. No.}	06	19652
	Physicia	an	Decedent's Name (First, Midd							2	2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Mary Loui 4a. Facility Name (If not institution				4b. City.	Town, or	Location of	of Death	June	4c. Count	y of Death	1 5 / 1 M
	Examin	er	Dorchester (-				ambr					rchest	ter
	Funeral		5. Social Security Number	6. Sex		rs. last birthday		1 Year	If Under	24 Hrs. 8	B. Date of Birth (Month, Day			place (State or Foreign
	Director		214-32-5539	1 □ M 254.F	69	Yrs.	Months	Days	Hours	IVIII.	Dec. 2			ryland
	p s	}	Usual Residence of Decedent 10a. State 10b. County	/	10c.	City, Town or L	ocation					,		0d. Inside City Limits
7	Aaryle r sho	ō		chester		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		urlo	~k					1 ☐ Yes 2 🛣 No
5	the h	Director	10e. Street and Number	- CHODECI			10f. Zip		-			0g. Citizen of	What Cour	ntry?
(3a or		4011 Kelkris	Circle					21643	}		USZ	4	
2	death	Funerai	11. Marital Status	12. Was De	ecedent Ever in	n U.S. 13.	. Was Dece	dent of His	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	14. Ra	ce - Americ	
2	or ite		1 ☐ Never Married 2 ☑ Mai	rried 1 Tes	s 2. XNo Give		1 ☐ Yes		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , ,	Speci		
Ś	hours urel',	d by	3 Widowed 4 Divorce	d Year or	Dates:	16a Door	edent's Usu	al Occupa	tion			16b. Kind of I		
2	in 72 in 72	Completed	(Specify only highe	est grade complete	·	(Giv	e kind of wo DO NOT u	ork done d se retired,	uring mos	t of working	9	TOD. KING OF	2031116332111	dustry
7	yiene.	шо	Elementary/Secondary (0-12)	College	(1-4or 5+)		accou	ntan	t			state	govei	rnment
2	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "naturel", or items 23a or 28a-f show indicate the natified at event, the Medical Exactifier rount be natified at	BeC	17. Father's Name (First, Middle	, Last)					18. Mothe	er's Name ((First, Middle,	Maiden Suma	me)	
	should b tnd Ments s marked umatic e	70	George E. J	Jones					L	ouise	Barto	n		
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other treumatic event, in a Medical Exactinat must be notified at any injury or other treumatic event, in a Medical Exactination.		19a. Informant's Name/Relation				•				Route Number			Code)
ອ ໜົ	1 and leelth sm 27 ther t		Elmore L. Woo	olford	husbanc	b. Place of Disc			Circ	ele, H	<u>Iurlock</u>	MD 20c. Location		own State
2	ages of of F		1 Burial 2 □ Cremation		m State	cemetery, cre	ematory or o	ther place					•	•
Saltimor	artme artme ortant injury		* 4 □ Donation 5 □ Other (tevensy	7111 C 22. Name ai			6/8/ √ ייי	omas F	Stever		
מ	Departiment Important		B. K.P	24.						11.	ridge,		1613	r.A.
Н			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	it caused the c									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ardia	1	nuthn							Onset and Death
	/Medical		resulting in death)	a	to (or as a con		9100							<u> </u>
	Examiner		Sequentially list conditions,	b										
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	to (or as a con	sequence or):								
	al-tra	xar	that initiated events resulting in death) Last	c	to (or as a con	sequence of):								
0/8	certificate be executed ading physician and use as the burial-transit	dicai		d										
Q	tificating bhy	ledi												
X Q R	res that the death certific igned by the attending f be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Liv	outcome of pre e birth 2 1	etal death 3	□Ectopic p						ate of delivionth	ery Day Year
	the attenhed for n	sici	1 ☐ Yes 2 MNo 9 ☐ Unknown	4 □ Pre 9 □ Un	egnant at time known	of death 5	Other (s	pecify)					ionar,	,
7.	that the ed by the detache	Phy	Part II. Other significant condit	tions contributing to	death but not	resulting in the	underlying	cause give	en in Part I		23e. Did to	bacco use co	ntribute to t	he cause of death?
g,	een signe		chroniz obstru	1	rones	Disease					1 U Y	es 2 No	3 🔀 Prol	pably 4 □Unknown
Kecords		lete		23	1	1 Hillian					24a. Was a	an 24b	. Were auto	ppsy findings available
	siclan: The law certificate has b irector, page 2 sh	Completed					_				autop perfor	sy	prior to co death? 1 \(\text{Yes} \)	mpletion of cause of
Vital	an: T tifficat tor, pi	a)	25. Was case referred to medic	al				-	26. Place	e of Death	1 ☐ Yes (Check only or		1 165	2010
	≥ . <u>e</u> o	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	Inpatient	2 ER/Outpati	ent 3 D	OA Oth	er: 4 □ Nu	ursing Hom	ıe 5 ☐ Resid	ence 6 🗆 O	ther (Specia	(y)
n of	fte		27. Manner of Death 1 X Natural 5 ☐ Pend		ite of Injury Ionth, Day Yea	r) 28b. Time Injury		28c. Injury Work			8d. Describe h	ow injury occu	urred	
<u>s</u>	tendi Jeath. tor: A the fu	cati	2 ☐ Accident inves	stigation		***	М		Yes 2		94 Location /6	trant and Alum	has as Du	ai Route Number,
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune	Certification:		mined 288. Pli	ilding, etc. (S)	At home, farm, s pecify)	street, factor	ry, office		2	City or Tow		noer or Hun	ai Houte Number,
_	spitel ours nerel filled		29a. Certifier 1 Certify	ring Physician: To	the best of my	knowledge, dea	ath occurred	at the tim	ne, date ar	nd place, a	nd due to the	ause(s) and r	nanner as s	stated.
	e Ho 124 h	Medical	(Check only 2 Medice one)	of Exeminer: On the	e basis of examination examiner stated.	mination and/or	investigation	n, in my o	pinion, dea	ath occurre	d at the time,	date and place	, and due t	o the cause(s)
	To the To the To the Comp	ž	29b. Signature and title of certif	jen /; /	01		29	c. License	a number			29d. Date sign	ed (Month,	Day, Year)
			100	10 (XX			D	508	04		6-	5-0	le
			30. Name and address of person		ause of death	(Item 23a) (Type	e, Print)				1	0		11/13
			Mark M 31. Date filed (Month, Day, Yea			ignature	Byen	ST.	reet		ambri	Lge, N	(I)	dileis
	Sta Regist	ate rar	JUK	9 5 2000	March	w D.	Acres	de						

State of Maryland / Department of Health and Mental Hygiene 1 1 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 **Physician** June 8, 2:47A Williams The1ma I. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 3,1915 Clinton Southern Maryland Hospital Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🖫 F 577-42-6026 Director Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location the Maryland 10a. State 10h County rthen "natural", or Itamis 23a or 28a-f show the Medical Examinar must be notified at 1- Yes 2 No Washington Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with t 817 Tewkesbury Place, NW United States 20012 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or lian any injury or other traumatic event. Ite Mudical Expenses 1 ☐ Yes 2 🛣 No 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: þ 3 Midowed 4 □ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Cosmetologist Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Ballard William Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7134 Fairway View Lane, Mariboro, MD. 20772 1/134 Falf Wa Upper Maribo 20b. Place of Disposition (Name of cometery, crematory or other place) Sadie Farrow/niece Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park 6/14/06 Landover, MD. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, MD. 20746 Approximate Interval Between Onset and Death 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ACUTE MYDIARDIAL INFARCTION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARRYTHMIA CARDIAC Sequentially list conditions, It any, leading to find editate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) Yes 2 No P.O. 9 Unknown 9 Milinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown PACENNAKER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 No 2 1 No 1 Yes the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 SER/Outpatient 1 ☐ Yes 2 ☑ No 3 DOA 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide in by 4 [] Homicide pelli Typ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D50689 06/08/2006 Anil K Mahagez MD PUSPITAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTHERN MARYLAND CLINTUN MD 20735 ROAD 7503 SURRATTES ANILK MOTHATON MD 31. Date filed (Month, Day, Year) 32. Spgistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 2 1 2006

			For State Registrar	State of Mar	-	artmer rtificat				Re	g. No.	2000	1965
	Physicia /Medic		Decedent's Name (First, Middle, Last HENRY			WH	ITE	•		Date of Death Month	Day 2	Year ZOO (
	Examin		4a. Facility Name (If not institution, give THE JOHNS HOPKIN 5. Social Security Number 6. Se	NS HOSPITA	(In yrs. last birthday	BA	LTIN r 1 Year	Location of LOCE If Under 2 Hours	CIT	B. Date of Birth (Month, Day, NOV 9,		9. Bin	thplace (State or Foreign
	Director		222-42-0150 Usual Residence of Decedent 10a. State 10b. County	- 3	O Yrs. 10c. City, Town or L	ocation				NOV 9, 1	1955	De	laware
	r 28a-f sho	irector	Delaware New Cast	1e	Newark	10f. Zij	Code			10	Og. Citize	n of What Co	1 ☐ Yes 2 📉 No ountry?
036	ges 1 and 2 should be liled within 72 hours after death with rine Maryland it of Health and Mentel Hygiene. It of Health and Mentel Hygiene. It of Health and Mentel Hygiene. It of Health and Mentel Hygiene. It of the traumatic event, It a Medical Examinar must be notified at	by Funeral Director	15 Cheswald Boul 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 QOrvorced	evard, Apt 12. Was Decedent Ev Armed Forces? 1 Yes, Give Year or Dates:	rer in U.S. 13.				in? (Speci Puerto Ri	ify Yes or No- can, etc.)	14	ited S Race - Ame Black, While Pecify: Wh	erican Indian,
21215-0036	I within 72 ho liene. r then "natur the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+	(Give	DO NOT U	ork done d ise retired	furing most		7		of Business inting	
/land	should be filed and Mentel Hygis marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Clarence Poe Whi		,			A1m	a M.				
	permit. Pages 1 and 2 sho Depertment of Health and Important: If Item 27 is my any injury or other traums		19a. Informant's Name/Relationship (7) Linda F. Cornaco 20a. Method of Disposition	hia/Sister	36 M	latthe	ews R	oad,		rk, Dela	awar	≥ 1971	
Baltimore,	permit. Page Depertment of Important: If any injury or once.		1 🖾 Burial 2 Cremation 3 🗆 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens)	Gracelay, cre Gracelay Park	n Men Licks	noria Home	20 ss of Facility for	006	1			, Delaware land 21921
7	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. MULTI-	he death. Do not er	nter the mo	de of dyin	g, such as o	cardiac or	respiratory arre	est,	, mary	Approximate Interval Between Onset and Death 2 WEEKS
	ate be executed nysicien and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. END-ST Due to (or as a	consequence of): AGE LIV consequence of):	IER	PIS	EAS	Ε				5 YRS
Bo	death certifica e ettending pl id for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic p					23	d. Date of de Month	livery Day Year
	w requires that the been signed by th should be detache	ed by Ph	Part II. Other significant conditions or	ontributing to death but	t not resulting in the	underlying	cause give	en in Part I.		1000	acco us	,	o the cause of death?
I Reco	The law ete hes b page 2 st	Complet								24a. Was an autops perform	y ned?	24b. Were a prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	ding Physicien: Th n. After this certificete funeral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Notural 5 Pending	Hospital: 1 (Monpatien 28a. Date of Injury (Month, Day	28b. Time		28c. Injun Worl	er: 4 🗆 Nur	rsing Home	(Check only only only only only only only only	nce 6		acify)
Divisi	To the Hospital or Attending Phys within 24 hours effer death. To the Funerel Director: After this of completely filled in by the funeral difference.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm, s (Specify)					Bf. Location (St. City or Town	reet and , State)	Number or R	lural Route Number,
	the Hosp hin 24 hou the Funel npletely fil	Medical	(Check only 2 Madical Examone)	ysician: To the best of ninar: On the basis of e and manner state	examination and/or	nvestigatio		pinion, deat		d at the time, da	ate and p	lace, and du	
	Twit O	2	29b. Signature and title of certifier Corolyn Daki 30, Name and address of person who	completed cause of de	ath (Item 23a) (Type	R Rint)	les-	000		J	UNE	, 2	2006
	2 Sta Regist	ate	CAROLYN DAMLEN 31. Date filed (Month, Day, Year) G 2006	THE JOHNS A	10PKINS nos	PITAL	,6001	Verth 1	waife	Stracet, B	ALTIM	ORE, M	ARYLAND 2128

DHMH 17 Rev 1/2001

			For State Registrar	State	of Maryla	•	artment of F rtificate of		•	rgiene Reg. No. 20	116	19655
			Decedent's Name (First, Middle	. Last)	-				2. Date of De		5,3 5,7	3. Time of Death
	Physicia	an	Clara Reba	_	or				Month		Year OO C	0540 M
	/Medic		4a. Facility Name (If not institution				4b. City. Town. o	or Location of Dea		4c. County of		<i>V</i> - /
	Examin		Peninsula Reg			Cont	,,	lisbury		Wicon		
			5. Social Security Number	6. Sex		s. last birthday,						ace (State or Foreign
	Funeral Director		219-05-3766	1□M 2 X F	101	Yrs.	Months Days	Hours Mir	r. (Month, Da Feb. 28		Count De 1	aware
			Usual Residence of Decedent		101				1 00.20	7 1705		
	/land		10a. State 10b. County		10c. (City, Town or L	ocation				10	Od, Inside City Limits
	Man	to	Maryland Wic	omico		Salis	bury					1 XYes 2 □ No
	r 28s	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Coun	try?
	h with	O E	1013 Powhatt	an Boul	vard		2180	1		U.S.A		
	ms 2	Funeral	11. Marital Status		cedent Ever in	U.S. 13.	Was Decedent of H	Hispanic Origin? ((Specify Yes or No		- America	
و	or Ite	Ē	1 Never Married 2 Marr		2 No		1 ☐ Yes 2 No	Specify:	5110 F110dF1, 010.7			iic.
2-0036	rali, c	by	3 Widowed 4 □ Divorced	Year or	Dates:		165 2/3/140	3pecny.		Specify:	Bla	ck
Q Q	72 hc	sted	15. Decedent (Specify only highes		d)	16a. Dece	dent's Usual Occup	oation during most of w	orkina	16b. Kind of Bus	siness/Ind	ustry
2	thin thin	npie	Elementary/Secondary (0-12)		(1-4or 5+)		kind of work done DO NOT use retire	d)				
2	M Per th	Completed	6			Dom	estic	T		None	,	
ng	be filed within 72 hours after deeth with the Manyland nat Hyglene ad other then "natural", or Items 23e or 28e-f ehow event, I'm Medical Exercises must be notified at	Be	17. Father's Name (First, Middle,							, Maiden Sumame	})	
<u> X</u>	should bind Menl	2	Walter Albe	rt Wal	ker				e Dashi			
Maryland 2121	2 sho and le m	1	19a. Informant's Name/Relations				ing Address (Street					
	ss 1 and 2 of Health Item 27		Margaret Sess	oms (Da				ttan Bl				
altimore,	of H		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from		cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - 0	Jity or Lo	wn, State
Ě	Pages ment of I		4 Donation 5 Other (S			reen i			-06	Salisk	oury	,Md.
Balt	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 le marked other then "natural", or Items 23a or 28a-f ehow appringuty or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service	Licensee Store	. 7	2	Stewart 821 West	Funera	l Home	,Md.218	201	
			23a. Part1. Enter the disease, or shock, or heart failure. List	, , , , , , , , , , , , , , , , , , ,	t caused the de						701	Approximate
			shock, or heart fallure. List Immediate Cause (Final									Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	a	o (or as a cons	TON.	PNEVMOR	11				
	Examiner			Due to	o (or as a cons	sequence or):	vlus					
		er	Sequentially list conditions, if any, leading to immediate	b	U (UI as à CONS	equence of).	0103					
	nsit	듣	cause. Enter Underlying Cause (Disease or injury	S								
	al-tra	Examin	that initiated events resulting in death) Last	c. Due t	o (or as a cons	equence of):						
8760,	cate be executed physicien and the burial-transit	dicail										
89	ficate g phy as the	0										
	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Ž	IF FEMALE: 23b. Was decedent pregnant		outcome of preg					23d. Date	e of delive	ry
Вох	atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		e binth 2∏Fo gnant at time o		□Ectopic pregnand □ Other (specify) _	:У		Mon	ith	Day Year
P.O.	the c by the achec	lys	9 ☐ Unknown	9□ Uni	known							
	res that igned b	by PI	Part II. Other significant condition	ons contributing to	death but not i	resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use contri	bute to th	e cause of death?
Division of Vital Records,	d big	D D							. 10	Yes 2 □ No	3 🔲 Prob	ably 4 @Unknown
00	w require been si should I	Completed							24a. Was	s an 24b. W	Vere autor	osy findings available
Re	he lav e has ige 2 :	Ĕ								ormed? de	eath?	npletion of cause of
ā	n: T ificati or, pa	e C	25. Was case referred to medica					OF Place of D	1 ☐ Yes leath (Check only		Yes	2LJ N0
5	Physicien: rthis certific ral director,	00	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 DOA Ot	hor		idence 6 □Othe	r (Snecih	·)
οţ	Phy or this aral d	٦: <u>٦</u>	27. Manner of Death	28a. Dat	te of Injury	28b. Time				how injury occurre		/
on	ding th:	ţ	1 ☐Natural 5 ☐ Pendir 2 ☐ Accident investi	ig .	onth, Day Year) Injury		ork?]Yes 2∐No				
S	il or Attending after death. I Director: Afte d in by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ce of Injury · A	t home, farm, s	treet, factory, office			(Street and Numbe	er or Rura	Route Number,
ă	after after din the	Certification:	4 Homicide	bui	liding, etc. (Spe	ecity)			City or 10	own, State)		
	Hospital 24 hours a Funeral letely filled		29a. Certifier 1 Certifyii	ng Physician: To t Examiner: On the	the best of my l	knowledge, dea	th occurred at the t	ime, date and pla	ice, and due to the	cause(s) and mar	nner as st	ated. the cause(s)
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha peompletely filled in by the funeral director, page	Medical	one) 29b. Signature and title of certifie	and ma	anner stated.			se number		29d. Date signed		
	F 3 F 8		177	1		1+1-	7	6299	95	6/0	1/2	no (.
7	3		00 North and 0 the	upo completed =:	/U	tom 230\ /Ti	Print	4-11		401	1	7
	S		30. Name and address of person	owno completed ca	M.O.		E. CANVI	51.	544564	no		
		ate	31. Date filed (Month, Day, Year,		. Registrar's Si	gnature	8 40					
	Regist	rair	JUN 0	5 2006	Simone .	A.F. A						

			State Registrar	,	artment of Health and	Mental Hygie	211116	19656
	Physicia	an l	1. Decedent's Name (First, Middle, Last)		initiate of Boain	2. Date of Death Month	Day Year	3. Time of Death
100	/Medic	al .	4a. Facility Name (If not institution, give street and	DOZIS number)	4b. Cily, Town, or Location of Deal	h	4c. County of Death	1940 "
	Funeral Director		Univ of Haryen 5. Social Security Number 6. Sex 165 32 8926	7. Age (In yrs. last birthday	Baltyma If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	None 9. Birthol County Penns	lace (State or Foreign try) sylvania
	ryland how		10a. State 10b. County	10c. City, Town or L	ocation		10	Od. Inside City Limits
	he Ma	ecto	Howard 10e. Street and Number	Colum	oia 10f. Zip Code	100	. Citizen of What Coun	1 ☐ Yes 2 ☑ No
	3a or	i Dir	10065 Windstream Drive	Apt 5	21044		United Sta	
920	permiti. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Heath and Mental Hyglene. Depirtment of Heath and Mental Hyglene. Important: if Item 27 is marked other then "natural", or items 23a or 28e-f show appringing or other traumatic event, Ina Madical Examinar must be notified at DRGs.	by Funeral Director	11. Marital Status 12. Was Armed 1 Never Married 2 Married 1 Yes		Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ Yeo Specify:		14. Race - America Black, White, &	an Indian,
21215-0036	within 72 ho sne. then "natur	Completed	15. Decedent's Education (Specify only highest grade comple: Elementary/Secondary (0-12) Colleger	(Giv. life.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) Mother	rking 16t	b. Kind of Business/Ind	ustry
Maryland 2	uld be filed Mental Hygie irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) John B. Mannion			me (First, Middle, Mai asker		
Mary	d 2 sho th and ! ?7 is me traum		19a. Informant's Name/Relationship (Type, Print) Thomas W. Yodzis/Son		ling Address (Street and Number or R Coattail Ct. Ell:			Code)
	es 1 an of Heat if item 2		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal for	rom State	ematory or other place)		c. Location - City or To	
Baltimore,	ii. Pag rtment rtant: njury c		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	Meadowr:	idge Mem. Pk. 6-9		lkridge, M	
Ba	Dep.		23a, Part1. Enter the disease, or complications the	yeu !	^{22. Name and Address of Facility} Ha: 4112 Old Columbia	Pike Ellic	cott City,	MD 21043
760,	Physician physician and physician and physician and physician and physician and the physician structure of the physician physi	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e to (or as a consequence of): a to (or as a consequence of): a to (or as a consequence of):	ell lung CA u Failure	uth me	tastases	Onset and Death
.O. Box 68	that the death certificat ed by the ettending phy detached for use as th	Physician/Med	in the past 12 months?		☐ Other (specify)		23d. Date of delive Month	ny N/A Day Year
S, D	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to th	e cause of death? ably 4 ∐Unknown
al Record	The law ate has b page 2 sl	Completed	Hyperchdesten	olemia		24a. Was an autopsy performed	d? prior to con death?	psy findings available npletion of cause of
f Vital	S 5	To Be	25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{Vo} \) Hospital:	1 X Inpatient 2 ☐ ER/Outpatie	Othor	ath <i>Check only one</i> Home 5 Residence	e 6 Other (Specify	·)
on of	ding PI h. After th funera		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury Month Day Year) 28b. Time Injury		28d. Describe how	injury occurred	
Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the mojetely filled in by the funeral	Certification:	3 Suicide 6 Could not be 28e. F	Place of Injury - At home, farm, souilding, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	at and Number or Rura State)	Route Number,
	To the Hospitel within 24 hours e To the Funeral E or mpletely filled	edical	(Check only 2 Medical Exeminer: On t		ath occurred at the time, date and plac investigation, in my opinion, death occ			
	To the within To the	Me	29b. Signature and title of certifie		29c. License number		Date signed (Month, I	
ē.	2-		30. Name and address of person who completed	Cause of death (Item 23a) (Type	- P18652		0/0/0	HIMMA
)0			TE ASARD U	niv Marylan	P 18652 a. Print) U Med CtR 22	5. Greene	St. M	nD 31201
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 8 2006	oz. magistiai s signature	Scart ,			

			1 - For State Registrar	State of Mary		artment of			giene 00	5 19657
100	y 16 m		Decedent's Name (First, Middle, Last	t)				2. Date of De	ath Day Yea	3. Time of Death
	Physici /Medic		Rosanna Young					Jun		12:37 a.Mn.
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of [Death	4c. County of De	ath
	40	11 th	21183 Abell Road				bell	U-a l		Mary's
	Funeral Director		220 34 7040	T. Age (In	yrs. last birthday Yrs.	Months Da		Min. 8. Date of Bir (Month, Da Feb 28		irthplace (State or Foreign Country) yland
	and W		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation.				10d. Inside City Limits
	Maryi f sho	Į.	Maryland St. Mary	1 a A1	bell					1 ☐ Yes 2 ☐ No
	289	Director	Maryland St. Mary 10e. Street and Number	S AI	DETT	10f. Zip Cod	le		10g. Citizen of What	Country?
	h with		21183 Abell Road			20606	5	t	nited Stat	es
	deat	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13	Was Decedent	of Hispanic Origin	? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ar Black, W	nerican Indian,
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2 💢 !			Specify: E	
Ö	72 hours after death with the Maryland Inaturel', or Items 23a or 28a-f show Isaal Exacilities at		3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	16a Dec	edent's Usual Oc	cupation		16b. Kind of Busines	s/Industry
7	J within 72 hours after death with the Marylan jiane. r than "naturel", or ftems 23a or 28a-f show the Markeal Examiner must be militied at	Completed	(Specify only highest gra	de completed)	(Giv	e kind of work do DO NOT use rei	ne during most o	f working	rob. Killa of Busilles	is/maamy
212	y within giene. r than "	ШО	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	maker			Own Home	
b	be filed ttal Hygid od other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	Maiden Sumame)	
<u>Vala</u>	should be and Mental I marked o	To	John Albert Thoma	S				Elizabeth		
Maryland 21215-0036			19a. Informant's Name/Relationship (Roderick Anthony T		4.0	_		or Rural Route Numbers	er, City or Town, State 7331	, Zip Code)
a)	ss 1 and 2 of Health a item 27 is rother tra		20a. Method of Disposition	2	Ob. Place of Disp		1	Date	20c. Location - City	or Town, State
imo	nit. Pages artment of l ortant: If it injury or o		1 N Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	()	Charles				6 Leonardt	
at	permit. Pag Department Important: I any injury o	1	21. Signature of Funeral Service Licer	14/4					d Funeral	
	2011		▶Kyle S. Simons							ryland 20650
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.			Syndra.		rrest,	Approximate Interval Between Onset and Death
	Examiner			Due to (or as #co	ensequence of):	leen	,			440
	ed isit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):					
,	be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):					
1760	a % a	cal		d						
68 ×	eath certificat attending phy I for use as th	Med	IF FEMALE:							
Box	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time	Fetal death 3	☐Ectopic pregna			23d. Date of o	lelivery Day Year
o.	at the de by the a	Physician/Med	1 ☐ Yes 2 🔊 No 9 ☐ Unknown	9 Unknown	o or death 3	Cities (specify	7			
٥.	that hed by deta	by Ph	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying cause	given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	w requires been sign should be							10	Yes 2□No 3X	Probably 4 Unknown
Records,	= 000	Completed						24a. Was		autopsy findings available o completion of cause of
Œ		S S						perfo 1 ☐ Yes	rmed? death	? es 2□ No
Vital	certifical rector, p	Be	25. Was case referred to medical examiner?	11				Death (Check only	оле)	
of \	Phys this al dii	5	1 Yes 2 No	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	ent 3L DOA			dence 6 Other (Si	pecify)
	Jing After fune	tlon	1 Natural 5 ☐ Pending	(Month, Day Ye		1	njuryat Work? 1 ∐ Yes 2 ∐ No		now injury occurred	
Division	or Attending after death. Director: After in by the fune	flca	3 Suicide 6 Could not b	e 28e. Place of Injury -	At home, farm, s			28f. Location (Street and Number or	Rural Route Number,
Ö	s after s after s Dire	Certification:	4 Homicide	building, etc. (S	Specify)			City or To	wn, State)	
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	Medical (niner: On the best of m niner: On the basis of exa and manner stated.	amination and/or					
	To th within To the	Me	29b. Signature and title of cert lier	,		1	ense number		29d. Date signed (Mo	
) Iami	u Go	~ m	0 D	41728		6/9/	06
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	e, Print)	4		21.	06 endfown, MD 2065
			DANA RUSSEL	L ST.Ma		spitel 2	25500 P4	Lockout	Kd Leen	entown, MD 2065
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	006 32 negistrar's	Signature	and i				

			1 - For State Registrar	State of Ma	ryland	•	artment o			fental Hy	giene Reg. No.	006	19658
	Physici	an	Decedent's Name (First, Middle, Last, Emma Eleanor		nger					2. Date of De Month	Day	Year 2006	3. Time of Death A. 01:05 M
	/Medic Examin		4a. Facility Name (If not institution, give		CENTE	R	4b. City, Tow SAL	n, or Locatio		1000	4c. Co	unty of Death	0110
	Funeral Director		220-28-0947	7. Age		st birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. s Min.	8. Date of Bir (Month, Da 3/11/1	th ay, Year) 932	9. Birthp Coun Mai	lace (State or Foreign try) Cyland
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomic			Town or Lo						11	0d. Inside City Limits 1X Yes 2 □ No
	with the	Dire	10e. Street and Number 1514 Riverside D	r. Ant. A	A222		10f. Zip Coo				-	of What Coun	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importint: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, i'm Medical Examinar must be notified at ODGE.	y Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S.		1	of Hispanic Cuban, Mexi		ecify Yes or No Rican, etc.))- 14.	Race - Americ Black, White,	
21215-0036	vithin 72 hour ne. han "natural e Medical Ex	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	cation	-)	(Give life.	dent's Usual Ockind of work do	ccupation one during m tired)	nost of work	ing		of Business/Inc	dustry
land 2	Jid be filed v fental Hygie rked other t tic event, in	To Be Co	12 17. Father's Name (First, Middle, Last) Howard Murrell			nous	ewile			e (First, Middle es Park	, Maiden Sur		
Mary	d 2 show th and h to ma trauma	1	19a. Informant's Name/Relationship (T) Ellen Younger Dick		hter					ai Route Numb Delmar			Code)
Baltimore, Maryland	Pages 1 an lent of Heal int: If Item 2 iry or other		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		20h Pla	ce of Disno	sition (Name o natory Memo	,	1	Date /2006	20c. Locati	ion - City or To	wn, State
Balti	permit. Depart Import eny in		21, Signal Service Licens	ampsa	CF	SP 22	HÖTTÖVÁ 501 Sno	y Funday Hil	ëral 1 1 Rd.	Home Pro	ofessi bury,	onal As MD 2180	ssociation 04
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line	9. ETM \$	STAT	er the mode of			or respiratory a		-	Approximate Interval Between Onset and Death
8760,	rate be executed whysicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a									
P.O. Box 68	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	2 ☐ Fetal c	death 3	Ectopic pregna Other (specif)				23d.	Date of delive	ry Day Year
	w requires thet been signed by should be deta	by	Part II. Other significant conditions co	ntributing to death bu	t not result	ting in the u	nderlying cause	given in Pa	rt I.	23e. Did t			e cause of death?
I Records,	The ate h page	Completed					-			24a. Was auto perfo		prior to con death?	osy findings available inpletion of cause of
Vital	Physician: The this certificate har al director, page	o Be	25. Was case referred to medical examiner? 1 Yes	lospital: 1	t 2□E	R/Outpatier	it 3□ DOA	Othor		h <i>(Ch</i> eck o <i>nly o</i> ome 5 ⊟ Resi		Other /Specific	
Division of	aling After fune	ation: To	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	/ 2	28b. Time of Injury	28c.	njury at Work? 1 □ Yes 2		28d. Describe)
Divis	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	(Specify)					City or To	wn, State)		Route Number,
	Hosp 124 hou 1e Fune Hetely fil	edical	29a. Certifier Cactifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner stat	examinatio	ledge, deatl on and/or in	n occurred at the vestigation, in n	e time, date ny opinion, d	and place, death occur	and due to the red at the time,	cause(s) and date and pla	d manner as sta ce, and due to	ated. the cause(s)
	To th To th comp	ž	29b. Signature and title of certifier	1				ense numb				gned (Month, L	* * * * * * * * * * * * * * * * * * * *
7	B		30. Nam and address of person who co	ompleted cause of de	ath (Item 2	23a) (Type,	Print)	(36)	76		. 7	406	≥ 1 <i>6</i> 01
	Sta	ate.	Ronato P -	32. Registra	r's Signatu	56	O RIV	ERS	DE	DR SI	HI350	RYMO	5 (BO1
Ž.	Regist		JUN 0 6 2	006	Mer d	4 4	Coretto						

DHMH 17 Rev 1/2001

			For State Registrar	te of Maryland / De	epartment of He Certificate of D		Reg. No.	5 19659
			Decedent's Name (First, Middle, Last)			2. Date of Month	Death	3. Time of Death
	Physicia /Medic		VIRGINIA ZIE	EGLER		JUNE	E And 200	6 19.57 M
ķ.	Examin		4a. Facility Name (If not institution, give street a		4b. City, Town, or Lo		4c. County of De	
			HOWARD COUNTY 5. Social Security Number 6. Sex	GENEERAL HOS	7	MBIA MD If Under 24 Hrs. 8. Date of		ARD irthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 M 2[Months Davs	Hours Min. (Month,	Day, Year) (laryland
			Usual Residence of Decedent					
	how	h	10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits 1 Yes 2 XNo
	Ba-f o	ecto	MD Howard	Glenel			10g. Citizen of What 0	<u> </u>
	with t	ក់	10e. Street and Number 14701 Triadelphia Roa	a	10f. Zip Code 21737		United S	
	death ms 23	nera	11 Marital Status 12. Wa	Decedent Ever in U.S.	13. Was Decedent of Hisp	panic Origin? (Specify Yes or	No- 14. Race - Ar	nerican Indian,
336	s I and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I them 27 is marked other than "naturel; or items 23s or 28s-f show item 27 is marked other than "naturel; or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 25 Married 1 If Y	ed Forces? Yes 2 XNo es, Give ir or Dates:		Mexican, Puerto Rican, etc.) Specify:	Black, Wh	hite, etc. hite
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade comp	leted) 16a. D	ecedent's Usual Occupation	on rina most of workina	16b. Kind of Busines	s/Industry
2	within one one one one one one one one one on	nple	Elementary/Secondary (0-12) Col	ege (1-4or 5+)	Give kind of work done dui ife. DO NOT use retired)	,		
	filed w Hygier other th	S	17. Father's Name (First, Middle, Last)	H	Iomemaker	8. Mother's Name (First, Mide	Own Home	
anc	d be f	o Be	John Joseph Pfarr			Ida May Cook	or of marger damaine,	
Maryland	should ind Men marke umatic	ဥ	19a. Informant's Name/Relationship (Type, Prin	nt) 19b. N		d Number or Rural Route Nur	mber, City or Town, State	, Zip Code)
	and 2 salth a n 27 ie		Gregory H. Ziegler/St	epson 147	'01 Triadelph	nia Rd Glenelo	g, MD 21737	
ore	000		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remova	cametani	isposition (Name of crematory or other place)	Date	20c. Location - City	or Town, State
Ē	Pag Iment tant: I		4 □ Donation 5 □ Other (Specify)	Metro	Crematory	6-7-2006	Catonsvil	
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee	11/2 M01044		^{of Facility} Harry H. Lumbia Pike El		
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	e on each line,		•	y arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Multi ORG	AN FAI	LORE		Onser and Death
	/Medical Examiner		resulting in death)	ue to (or as a consequence of)	:			
		e		ue to (or as a consequence of)				
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	PER ITO	VITIS			
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9			IF FEMALE: 23c If w	es, outcome of pregnancy			22d Date of d	
Вох	eath certif ettending for use as	clan	in the past 12 months?	Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of d Month	Day Year
P.O.	that the de ned by the e detached f	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐	Unknown				
	law requires that the death certi es been signed by the ettending 2 should be detached for use a	by P	Part II. Other significant conditions contributing	1 1	11 '4"	in Part I. 23e. D.	id tobacco use contribute	to the cause of death?
ord	w require been sign	ted	unmic cos	tructive	Fortin organ	y Hisax 11	☐ Yes 2 ☐ No 3 ☐	Probably 4 Unknown
Records,	lawr nesbe e 2 sh	Completed				24a. W	stopsy prior t	autopsy findings available completion of cause of
al H	: The licete he					1 ☐ Ye	erformed? death s 200 No 1 □ Y	
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital	: 1 Inpatient 2 ☐ ER/Outp	Other	26. Place of Death Check on		
of	ding Phys th. After this funeral dir	 	27. Manner of Death 28a	Dite of Injury 28b. Tin	ne of 28c. Injury a	4 Nursing Home 5 R	be how injury occurred	эесту)
ion	ttending deeth. ctor; Aft y the fun	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inju		s 2 No		
Division	al or Attending s efter deeth. il Director; After id in by the fune	Certification;	3 Surcide 6 Could not be determined 28e	Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Locatio City or	n (Street and Number or Town, State)	Rural Route Number,
	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the	Medical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, on the basis of examination and/				
	To the vithin 2 To the comple	Me	29b. Signature and title of certifier	1.0	29c. License r	number	29d. Date signed (Mo	nth, Day, Year)
) / (· /	ulle	22/	706	6/5/0	6
906	-		30 Name and address of person who complete MOMAMED K	d cause of death (Item 23a) (T	2717 HAM	MONDS FERR	RY ROAD.	BALT. 40.
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 8 2006	32. Redistrar's Signature	South			

State Registrar

Division of Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

MD

29d. Date signed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9661 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death June Physician 8:30 A.M. 20,2006 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner General Hospital Carrell County Westminster Carrol If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** 1 XM 2□ F 76 224-30-1764 North Carolina 16,1929 Director Usuel Residence of Decedent permit. Pages 1 end 2 should be tiled within 72 hours after deeth with the Maryland Depentmant of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Baltimore Mary land Funeral Director 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 21225 United States Round 3401 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ② No Specify: Black Š Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) United States Army College (1-4or 5+) Technician 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Armstrong Mary Julius Liverman 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 3401 Round Road Ellen Armstrong-Wife 20b. Place of Disposition (Neme of Date 20a. Method of Disposition 20c. Location - City or Town, State June 26 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Calvin L. Williams Faneral Service, P.A. 21. Signature of Funeral Service Licensee Maryland 21229 P.O. BOX 11651 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) (s cular Examiner Physician/Medical Examiner attending physician and R Hospital or Attending Physician: The law requiras thet tha death certificeta be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Lest Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the should be datached 3 ☐ Probably 4 ☑ Onknown 1 Yes 2 No é 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? certificate hes 1 Tes 2 1100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 25 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 2 ER/Outpetient 3□ DOA this Director: After the 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 Tyes 2 🗆 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours of To the Funeral Di completely filled in VC Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner steted. edicai 29a. Certifier (Check only 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mule 6/20/06 D47683 MO 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Reistertown Kaymond Miller Main Shut Sinte Zus

State

31. Dete-filed (Month, Day, Year) JUN 2 2 2006 Registrar

🕵. Registrer's Signature

as de

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Deads **Physician** nare 7.02 PM 20 06 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPITAL BALTIMORE SAMARITAN 5. Social Security Number 139-28-2069 tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 00112 Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County "naturaf', or Itama 23a or 28a-f show 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number adyside . Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 Mo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. PO NOT use retired)

HOML MaReu 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) 12th 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is ra any injury or other traum 1530 Shadybede Rd Balto, md, 21218 Daughter Valerie warker 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Crounsiile Veticem 6-26-06 Other (Specify) * 4 Donation 22. Name and Address of Facility 2470 Fred HILTON Pass eral Service Ligense Gang P. March Tuneral Home Baeto, md, 2, 29 the distance or complications that caused the death. Do not enter the move of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate av e (Final disease or condition Physician BRAIN INJURY ANOXIC /Medical resulting in death) Examiner CARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, PNEUMONIA, CONGESTYE HEART FAILUKE, 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS, REMAL FAILURE, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No HYPERTENSION 2 No 26. Place of Death Check on one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Xam 000 06-20-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIVEDITA PANDEY, 560/ LOCH RAYEN BIND, BALTIMORE, MARYLAND-21239

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 2 2006

ORIGINAL

32. Ragistrar's Signature

Carrington Henry Bonner

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 19663

		- For State		Cer	tificate	of Dea	th			F	Reg. No.	C	UU	0 1001
Physicia		1. Decedent's Name (First, Midd	le,Last)							Date of De	ath Day	Voo		3. Time of Death
ledical Examin		CARRINGTON	HENRY B	ONNER						Month June 17,		Yea		0950 hrs
		4a. Facility Name (if not institution	on, give street and no	umber)		4b. City,	Town, or Lo	ocation of	Death		40	. County o	f Death	
		10902 Huntcliff Court	Apartment 4			Owir	ngs MIIIs				E	Baltimore	e Cour	nty
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday) If Un	der 1 Year	If Under	24Hrs. 8	B. Date of E	irth (MM.	/DD/YYYY	9. Birth	place (State or
Director		218-56-2176	1 X M 2 F	54		Yrs. Mont	hs Days	Hours	Min.	11/1	7/1	951	Foreign	MARYLAND
	F		1 2 M 2 F			113.								**
any		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	ocation	_							10d. Inside City Limits
<u>* .</u>	-1		TIMORE			MILL	C						1	1 Yes 2 XNo
Aaryland 28a-f show Lat once,	희		LIMOKE	OW.	TINGS						40 - 04			
Mary 28a	Director	10e. Street and Number	71. TEE . GO	IID	ош 4		p Code	7			10g. Cit	izen of Wh	at Count	гуг
ith the Maryland 23a or 28a-f sho notified at once.		10902 HUNTO	TLIFF CO	URT, A	PT 4		2111	/				USA		
ms 2.	Funeral	11. Marital Status	A	cedent Ever in U	.S. 13.	Was Deced					-01	14. Race White		an Indian, Black,
deatl	٦	23	1XX Yes	2 NO						Jan, 1919.			,	
after	ğ.	3 Widowed 4 Div	vorced If Yes, Give Ye	ar ARI		Yes						Specify:	BLA	.CK
ours		15. Decedent's Education (Spe	cify only highest gra	de completed)		edent's Usua					16b.	Kind of Bu	siness/In	dustry
72 h	풀[Elementary/Secondary (0-12)		1-4 or 5+)			-	0011010		,				
5-0036 iled within 7 Hygiene.	Completed	12TH	2 YE	ARS	CARE	E GIV								E LIVING
5-0 Fed w othe		17. Father's Name (First, Middle	, Last)				1:			irst, Middle		Surname))	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	a	WILLIAM BO	NNER					GRA	CE J	JACKS	ON			
ould Me d Me itic ev	유	19a. Informant's Name/Relation:			10.0	ailing Addres	•					•		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If them 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		GRACE J. BOI	NNER / M	OTHER		PIC								
Heal		20a. Method of Disposition 1 X Burial 2 Cremation	- 0 Dames at			sposition (Na				Date	20c.	Location -	City or 1	Town, State
Baltimore, permit. Pages 1 al Department of He Important: If ite				rom State M	D VE'I	referan Son F	S CEI	쒸•	6/23	3/06	OW	TNGS	: мт	LLS, MD
Baltimo permit. Page Department o Important: injury or oth	ŀ	4 Donation 5 Other S 21. Signature Funeral Service		- X										ME 21207
Balti permit. Departm Import		1/1/1/10	1X.	Addi	7									MORE, MD
Physician		23a. Fart I Enter the disease, of	r complications that	caused the death	o not en	ter the mode	e of dying, s	such as ca	rdiac or re	espiratory a	rrest, sh	ock, or hea	art	Approximate Interval
/Medical	Ţ		1 4 1											Between Onset and Death
kaminer	- 1	Immediate Cause (Final diseas or condition resulting in death)		ral hemorifia a consequence of										
			h	a consequence c	,,,,									
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ੂ ਜ਼ਵਾ	Physician/Medical	UNPENDED	AMENDED											
760, ficate b g physic the bu	8	IF FEMALE: 23b. Was decedent pregnant in		, outcome of preg			. [23	3d. Date of		
68° certifi ding	ä	past 12 months?	Dree	birth mant at time of de		Fetal deat		Ectopic	pregnanc	у	Į	Month	D	ay Year
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the day	튑	Part II. Other significant cond			resulting in	the underlyi	na cause ai	ven in Par	rt I.	23e. Dic	tobacco	o use contr	ibute to t	he cause of death?
ords, P.O. Box 68. w requires that the death certifi s been signed by the attending should be detached for use as		T die in other organical control	tions continuously											ably 4 🗸 Unknown
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Reco	E										formed?		death? ✔ Ye	s 2 No
rtiffc		25. Was case referred to medic	al				26.Place	of Death (Check on	ly one)				
/ita	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpa	itient 3	DOA	Other ₄	Nursing	Home 5	Resid	ience 6	✓ Other	Scene
of \ g Ph; her th	-1	27. Manner of Death	28a. Dai	te of Injury hth, Day,Year)	28b. Time	e of Injury	28c. Injur	y at Work	? 2	8d. Describ	e how in	ijury occurr	ed	
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Division of Vital Records, tal or Attending Physician: The law requir rs after death. "I Director: After this certificate has been sted in by the funeral director, page 2 should	Certification:	det	uld not be termined (Specifi							or Town	, State)			
ospit hour nnera		4 Homicide 29a. Certifier 1 Certifying	Physician: To the b		dae death	occurred at t	he time do	te and nin	ice and di	ue to the co	use/e\ ~	and manner	r ge etart	ed .
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buril.	Medical	(Chack anh) Certifying	aminer:On the basi	s of examination	and/or inves	stigation, in	my opinion,	death occ	curred at t	he time, da	te and p	lace, and o	due to the	e cause(s)
To t with To t	led	29b. Signature and title of certif	and manner	stated.			29c. License							nth, Day, Year)
	=						O.C.N					ne 18, 2		/ /
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3		30. Name and address of person				tract D	I Alian a A	MD 040	01					
9			ant Medical Ex	AR .		treet, Ba		VID 2 12	U I					
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		For 1 - State Registrar		epartment of Health and I Certificate of Death	Mental Hygier Reg. I	4000	19664
Physici	an	1. Decedent's Name (First, Middle, Last)	BLACKLESG	E		Day Year	3. Time of Death
/Medio Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	JUNE 1	4c. County of Death	1752
- down		Narthwest Hospital		Randallston		Baltin	
Funeral Director		200 5 1 2130	14 000	rs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	1940 9. Birth	olace (State or Foreign
fand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		1	10d. Inside City Limits
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with th	Director	10e. Street and Number	. 4	10f. Zip Code 2//33	10g. (Citizen of What Cour	ntry?
deeth	Funeral	4138 hennygree	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	can Indian,
72 hours after deeth with the Maryland "naturel", or Itema 23a or 28a-f show olical Examinant must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	o rican, etc.)	Black, White,	etc.
n 72 h	etec	15. Decedent's Edu (Specify only highest grade	e completed)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king	Kind of Business/In	dustry
2 should be filed within and Mental Hygiene. Is marked other then "eumatic event, the Mental Hygiene".	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Supervisor		General	Motors
ntal Hy	Be	17. Father's Name (First, Middle, Last) William D. B	lackledge Sr	1	ne (First, Middle, Maid		
should be nd Mental marked o	은	19a Informant's Name/Relationship (Ty	na Print) 10 19h	Mailing Address (Street and Number or Ru	IS2NN		Code)
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permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr one.		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State	IN THE THINK	23/04 Du	Location - City or To	s, Md.
permit. Page Department (Important: If any Injury or		21. Signature of Funeral Service License	90	22. Name and Address of Facility			
		23a. Papi. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the death. Do no	5240 Rei 57 (540 w) ot enter the mode of dying, such as cardiac		Himore 14	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	©	C COPDNAM VASCUL	ar DISEA	4E	Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certif within 24 hours effect death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	Day Year
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Physician: The law Physician: The law r this certificate has b ral director, page 2 si	CO	25. Was case referred to medical		26 Place of Dea	performed 1 Yes 2 1		2 No
hysicia his cert	To B	examiner?	lospital: 1 ☐ Inpatient 2 ØER/Out	patient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specifi	y)
ding P	tion:	27. Manner of Death 1	28a. Date of Injury 28b. Ti (Month, Day Year) In	me of 28c. Injury at jury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
To the Hospital or Attending Physician: The within 24 hours either death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fare building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
Hospita 24 hours Funeral etely filled	edical C	29a. Certifier 1 Certifying Phy. (Check only one) 1 Medical Exami	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as st and place, and due to	lated. the cause(s)
To the within To the	Me	29b. Signature and title of certifier		29c. License number	29d. C	Date signed (Month,	Day, Year)
0			r,hO	D0055441		11NE 16	2,2006
, 2		30. Name and address of person who co	mpleted cause of death (Item 23a) (1	LCOURT ROAD R	andallston	nimb	Z14033
Sta Registi		31. Date filed (Month, Day, Year) JUN 2 2 201	32 Registrar's Signature	29c. License number DOOSTS 441 Type, Print) COURT ROAD R			

			L_State	ryland / Department of Health and I Certificate of Death	
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2. Date of Death 3. Time of Death
	Physicia /Medic		William T Bur	nett	June 14 2006 1428 M
	Examin Funeral Director	40		4b. City, Town, or Location of Death A Center Salt more (In yrs. last birthday) Yrs. Months Days Hours Min.	4c. County of Death A 8. Date of Birth (Month, Day, Year) AAV 6, 1955 4c. Country 9. Birthplace (State or Foreign Country) MAN 6, 1955 MARYLAND
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	h the Mai or 28a-f s	Director	MARYLAND N/A 10e. Street and Number	101. Zip Code	1 ORE CITY 1 No 1 No 2 No 1 No 2 No 1 No 2 No 1 No 2 No 1 No 2 No 1 No 2 No 2
	th wil		413 KOBERTS ST	REET 2121'	7 USA .
36	72 hours after death with the Maryland natural; or Items 23e or 28e-f show dical Exeminat must be notified at	by Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 12. Was Decedent E Armed Forces? 1	If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black It
5-0036	2 hou	ted	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
21215	filed within 72 Hygiene. Ither then "ni ent, the Medi	Completed by	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+	(Give kind of work done during most of wor life. DO NOT use retired) SERVICE SUPE	RVISOR OFFICE CLEANERS
	be filed tat Hygid d other svent.	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden Sumame)
yla	should be nd Menta! s marked o	P	JAMES	GURNETT MAR	Y MANGUM
re, Maryland	1 and 2 Health a em 27 is		19a. Informant's Name/Relationship (Type, Print) MARY BURNETT CMOTH 20a. Method/of Disposition	19b. Mailing Address (Street and Number or Hy 20b. Place of Disposition (Name of cemetery, crematory or other place)	All Route Number, City or Town, State, Zip Code) LN, APT 3 14 BH TO NL 2 1207 Date 20c. Location - City or Town, State
E O	Pages nent of int: if it iry or o		V⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	KING MEM. PARK 06	24-06 WOODLAWN, MD.
Baltimore,	permit. Page Depertment Important: If any injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 3 R	DOWN TR. FUNERAL HOME NAVE, BALTO, MD. 21217
			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not enter the mode of dying, such as cardiac	cor respiratory arrest, Approximate Interval Between Onset and Death
- Alexander	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Let 1 Due to (or as a	CA ischemic cerebra	1 infact
N Averly	LAdimine	7.0	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of).	
W	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		
0,	ate be executed hysicien and the burial-transit		that initiated events resulting in death) Last C. Due to (or as a	consequence of):	
8760,	cate be ex physicien a the burial	dicai	d		
9	e as t	Med	IF FEMALE:		
P.O. Box	The law requires that the death certific the last been signed by the attending proage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
	s that ned b e deta	by PI	Part II. Other significant conditions contributing to death but	t not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
rds	w require been sig should b	edk	Hypertension		1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	ician: The law recertificate has be	Completed	congestive heart fa	ilure	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
/ita	cian: sertific ector,	Be	25. Was case referred to medical examiner? Hospitat:	104	ath /Check only one)
of	Physician: this certific ral director,	٠ <u>۲</u>	1 ☐ Yes 2 ☐ No Prospital: 1 X Inpatien 27. Manner of Death 28a. Date of Injury		ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
Division	ttending death. stor: After / the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No ry - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number.
οį	al or A after i Dire	Serti	4 Homicide determined building, etc.	(Specify)	City or Town, State)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (f my knowledge, death occurred at the time, date and place examination and/or investigation, in my opinion, death occured.	
	To the Within To the Comp	Ř	29b. Signature and title of certifier M	29c. License number Pi5899	29d. Date signed (Month, Day, Year)
	.5		30. Name and ad ss of person who completed cause of de	ath (Item 23a) (Type, Print)	7:111:02
		ate.	31. Date filed (Month, Day, Year) 32. Degistral	r's Signature	U. CIIIOX
	Sta Regist		JUN 2 2 2006	a Is Specili	
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ORIGINAL

			101	epartment of Health and Me Certificate of Death	ental Hygien Rag. N	2000 15000
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici		Janie	BROOK	Month D	8 2606 1.22 AM
N.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
4	LAGIIII		The John Hopkins Hold tal	BAltiMORE		NA
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		B. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign
	Director		214-58-5403 10M 200F 57 Yr		JUNE 14	949 MARULAND
	D .		Usual Residence of Decedent			
	how	_	10a. State 10b. County 10c. City, Town of	r Location	a	10d. Inside City Limits
	e Ma	cto	MARYLAND N/A	BALTIMOR	ECIT	1 MYes 2 No
	or 28	ire .	10e. St/eet and Number	10f. Zip Code	10g. 9	tizen of What Country?
	within 72 hours after death with the Maryland ane. then "natural", or iteme 23a or 28a-f ahow ha Madisal Examiter inset be notified at	Completed by Funeral Director	4864 GREENCREST ROAD	21206		USA.
	deg deg	Inel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
36	or h	Į,	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 Ā No Specify:		Specify:
21215-0036	ural',	P	3 Widowed 4 □ Divorced Year or Dates:			BLACK
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2	giene.	E	Elementary/Secondary (0-12) College (1-4or 5+)	P. S. DO NOT use retired)	0	LUCAL STARE
	filed v Hygie ther i		17. Father's Name (First, Middle, Last)	18. Mother's Name (ON VENIENCE STORE
Maryland	e da b	Be	Ta = 1	10. Would straine	I'llst, Mildule, Maide	N 30111a111e)
Ž	d Meni	2	JAMES A. JEG	lailing Address (Street and Number or Rural)	Contract of City	DOKSEY
Mal	d 2 sho lth and lth and traum		19a. Informant's Name/Relationship (Type, Print) 19b. N	lating Address (Street and Number of Hura)	Houte Number, City	or rown, State, Zip Code)
	1 end Health em 27 Ither tr		20a/Method of Disposition 20b. Place of D	isposition (Name of Da	te 200 I	Location - City Town, State
Baltimore,	Pages nent of H int: If Ite		1 Burial 2 Cremation 3 Removal from State	crematory or other place)	200.1	Location - City of Town, State
Ë	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (Specify) METRO	OCREMATORY :06 -2	7-06 131	ALTIHORE MARYLAN
39	permit. Departr Importa eny inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	ROWNJA	FUNERALHEME
_	<u>a</u> 0 = a		Latich IV. Williams	2140 N. FULTON	1	LTO, MD. 21217
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
4	Physician	ŀ	Immediate Cause (Final disease or condition	nhalism		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of)			11000
	Examiner		Sequentially list conditions b.			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
6	nd	Examin	Cause (Disease or injury that initiated events c.			
Ö,	e exe	Ä	resulting in death) Last Due to (or as a consequence of)			
8760,	cate be executed physicien and the burial-transit	dicai	d			
9		Ž.	IF FEMALE:			
Вох	tendi tendi	an/	23b. Was decedent pregnant in the past 12 months?	3 ☐Ectopic pregnancy		23d. Date of delivery Month Day Year
	b dea	Physician/Me	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month Day Year
P.0	at the	h	9 Unknown		-	
	The law requires that the death certific 11e has been signed by the attending p 2ge 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		use contribute to the cause of death?
ord	equir en s ould	ted	HENATITIS C		1 Yes 2	2 ☐ No 3 ☐ Probably 4 ☑ Unknown
Records,	lawr as be 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Œ	The ste his	E O			performed? 1 ☐ Yes 2 🗸 📉	death?
of Vital	in rtifica	Be	25. Was case referred to medical	26. Place of Death (
>	Physicien: r this certificatal director.	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpi	atient 3 DOA Other: 4 Nursing Home	e 5 Residence	6 ☐Other (Specify)
0	ig Ph ter th neral	Ë	27. Manner of Death 28a. Date of Injury 28b. Tim 1 ☑ Natural 5 ☐ Pending (Month, Day Year) Inju	e of 28c. Injury at 28 Work?	d. Describe how inju	ury occurred
<u>.</u>	Attending or death.	atic	2 Accident investigation	M 1 Yes 2 No		
Division	or de by th	l≌	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office 28	3f. Location (Street a City or Town, State	and Number or Rural Route Number,
	To the Hospital or Attending Physicien: The lav within 24 hours effect death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;			,	
	hour uner ty fill	cai	29a. Certifier (Check only 1 ☐ Certifying Physicien: To the best of my knowledge, c 2 ☐ Medical Exeminer: On the basis of examination and/c	leath occurred at the time, date and place, an	nd due to the cause(s	s) and manner as stated.
	the H in 24 the F	Medicai	and manner stated.		at the time, date at	nd place, and due to the cause(s)
	To To I	Σ	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
			lery Paper lee	RES-000	11/14	nc 197006
-	2		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		1
	<i>_</i>		Alex Papangelow THE JOHNS	HOPRINS HOSP. 600 N	WOLFE ST.	BALTO, HD, 21287
33	Sta		ST. Date filed (Month), Day, Your)	- N.		
	Regist	rar	JUN 2 2 2006 See &	GONEU		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Year **Physician** Betts 08:40 AM he dore Tete 21 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Baltimore Harbo If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In yrs. last birthday) VIRGINIA 219-28-9921 1**⊠**M 2□F Months Days Hours .07,1931 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? HENRIETTA STREET USA. 41 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) INISHER 17. Father's Name (First, Middle, Last) (UNKNO :UN) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 9008. BARKSDALE LUYESTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 'S (DAUGITTER) W. HENRIETTA ST. BALTO, MD, 2/236 YOLANDA BETT 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1. Burial 2 ☐ Cremation 3 ☐ Removal from State EDAR HILL CEME, 06-27-06 BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN TR. FUNERAL ITO ME TO SEPH HE BROWN TR. FUNERAL ITO ME TO N. FULTON AVE., BALTO, MO 2121 21. Signature of Funeral Service Licensee , BALTO, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Septic Immediate Cause (Final disease or condition resulting in death) Days **Physician** Shock /Medical Due to (or as a consequence of): **Examiner** Emplement Due to (Jr.) a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit 2 years Due to (or as a onsequence Cante Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probebly 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 📝 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P1843713PQAW June 21,2006 MVperson who completed cause of death (Item 23a) (Type, Print) 3001 South Hanover Great, Baltmore, MD 21225 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State JUN 2 2 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

06-04188

JOHN BLACKBURN Please Type or Print in Black Indelible Ink UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0315 hrs **Medical Examiner** JOHN June 17, 2006 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c County of Death University Hospital Shock Trauma Baltimore If Under 1 Year | If Under 24Hrs. 9 Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (MM/DD/YYYY 5 Social Security Number **Funeral** Country marylar -08. Director Usual Residence of Decedent 10a State 10c. City, Town or Location or items 23a or 28a-f show must be notified at once. Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 303 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White etc 1 Never Married 2 Married Yes MD 21215-0036
2 should be filed within 72 hours after of hard Mental Hygiene
2 Tis marked other than "natural", or marite event, the Medical Examiner If Yes, Give Year or Dates: 1 Yes 2 No specify 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 -molher Pages 1 and 2 shument of Health and tant: If item 27 is 3)ackbu 20a Method of Disposition 20b. Place of Disposition (Name of cemetery other crematory or other place) Department of Important: 1 'n P. march Reneral Home disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** nly one cause on each line Between Onset and /Medical a Multiple Gunshot Wounds Death Imme Me Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and burial - trar Physician/Medical UNPENDED **AMENDED** phy: the b IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknowr P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? \$ 1 Yes 2 V No 3 Probably 4 Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' Yes 2 ✓ Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✓ Other: Scene this 2 1 🗸 Yes 28a. Date of Injury FOUND: 28d. Describe how injury occurred 28b Time of Injury 27 Manner of Death 28c. Injury at Work? Medical Certification: Subject shot Natural FOUND: Pending 1 Yes 2 V No 24 hours after death. Funeral Director: the Jun 17, 2006 0237 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 2800 Block of Ellicott Drive, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. within 2 To the 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. June 17, 2006 30. Name and address of person who completed cause of death (Item 23a)

State Registra

Ana Rubio MD

31. Date filed (Month, Day

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#14,perFH, \$35,6/22/06 TI

Amend it

		•	1 - For State Registrar	'State' o	of Marylan		irtment of H tificate of L			Reg. No.	5 19669
	Physici /Medic		Decedent's Name (First, Midd		rnest H.	Brow	1		2. Date of De Month	Day Ye un 18, 2006	3. Time of Death 12:25 p M
	Examin		4a. Facility Name (If not institution	on, give street and no 19 North Smal		et	4b. City, Town, or		th imore	4c. County of D	Peath N/A
	Funeral Director		5. Social Security Number 213-32-4945	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 102		tf Under 1 Year Months Days	If Under 24 Hrs Hours Min		th y, Year) , 1904	Birthplace (State or Foreign Country) Maryland
	aryland show	J.	Usual Residence of Decedent 10a. State 10b. County	N/A	10c. Cit	y, Town or Lo		ltimore			10d. Inside City Limits
	with the M or 28e-f	Directo	Maryland 10e. Street and Number 1719 North Smallwo			· · · · · · · · · · · · · · · · · · ·	10f. Zip Code	21216		10g. Citizen of What	Country?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show many injury or other treumatic event, I'm Medical Evarili or must be multised at ODGe.	by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Dec Armed F rried 1Yes If Yes. G	2 ☑ No ive		Was Decedent of Hi f Yes, specify Cuba □ Yes 2 X No	spanic Origin? (Specify Yes or No rto Rican, etc.)	- 14. Race - A	vencan Indian, White, etc. DIACK White
21215-0036	d within 72 hor giene. ir then "naturi I'm Medical I	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed College) (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired Tea	uring most of wo	orking	16b. Kind of Busine Baltimore Cit	bss/Industry by School System
land	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle	, Last) aiah Brown				18. Mother's Na		Maiden Sumame) ortha Colby	
Maryland	nd 2 shot alth and M 27 is mai		19a. Informant's Name/Relation Hazel I. Brown Wife	ship (Type, Print)						er, City or Town, State, Maryland 212	
Baltimore,	Pages 1 a ent of Hea nt: If item ry or othe		20a. Method of Disposition 1 🗶 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (/	semetery, crer	sition (Name of natory or other place us Memorial F		Date 06/23/06	20c. Location - City Baltimor	or Town, State e, Maryland
Balti	permit. Departm Importer any inju		21. Signature of Fineral Service		Esta		. Name and Addres	s of Facility others Fund	eral Service, Baltimore, Mo	P. A.	
	Physician	í	23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition	or complications that it only one cause on	each line.	n. Do not ent	er the mode of dying		ic or respiratory a		Approximate Interval Between Onset and Death
	Medical Examiner by physician and street burial-transit	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a conseq	uence of): UTEN- uence of):					
P.O. Box 68760,	death certi re attending ad for use a	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	utcome of pregna birth 2 ☐ Feta nant at time of d	it death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
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ion of Vital	Attending Physicien: There death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medic examiner? 1 Yes 2 Voo 27. Manner of Death 1 Natural 5 Pend 2 Accident inves	Hospital: 1 28a. Date		ER/Outpatier 28b. Time of Injury	28c. Injury Work	er: 4 🗆 Nursing		one) dence 6 □Other (S how injury occurred	Specify)
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	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	ledical C		I Examiner: On the						cause(s) and manne date and place, and	
	To th within To th comp	Me	29b. Signature and title of certif	er Deille	mun		29c. License D 0 0	number 9586	50	29d. Date signed (M	onth, Day, Year)
	12		30. Name and address of perso		use of death (Item	n 23a) (Type,	Print) 333	3 N. C	ALVENT	ST. B.	20, 2006 1270, MD 21218
	Sta Regist		31. Date tiled (Month, Day, Yea		Registrar's Signa	ature	boards		-		21 4 8

06-04200 Floyd Bridges

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Cei	rtificate o	f Deat	h			R	eg. No.	20	UD !	901
Physicia	an/	1. Decedent's Name (F	irst, Middle,Last							2.	Date of Dea Month	ith Day	Year	3. Time of De	
edical Exami	ner	FLOYD		BRIDGE							June 17,	2006		1520 hrs	3
		4a. Facility Name (if no 233 South Cor			ber)		4b. City, Baltir	Town, or Lo nore	ocation of	Death		4c.	County of Dea	th	
Funeral		5. Social Security Num	ber 6. Sex	7	. Age (In yrs. I	ast birthday)		er 1 Year	If Under		8. Date of Bi	rth(MM/E		irthplace (State of	or
Director	1	229-50-600		M 2 F	6	66 <u>Yrs</u>	Month	s Days	Hours	Min.	JULY	19,	, 193 ^{Fore}	ou V NRGI	NIA
any		Usual Residence of De 10a. State 10b	cedent . County		10c. City	, Town or Loca	ion							10d. Inside Ci	ity Limits
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fter d	by Fi	3 Widowed	4 Divorced	If Yes, Give Year or Dates:	2 <u>23</u> NO	1	Yes 2	X No	specify:				Specify: W	HITE	
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2121 uld be fil Mental I marked c event,	To B	19a. Informant's Name	Relationship (T)	pe, Print)		19b. Mailin	g Address	S (Street a	:		al Route Nu	mber, Cit	y or Town, Sta	te, Zip Code)	
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Baltimore, permit. Pages 1 an Department of Hee Important: If ite		21. Signature of Funera		ee	1								ERAL H		
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n of ding P		27. Manner of Death 1 X Natural 5	Dending	28a. Date of (Month, I	i Injury Day,Year)	28b. Time of	Injury .	28c. Injury	at Work?		3d. Describe	how inju	ry occurred		
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Division Hospital or Attendii 24 hours after death. Funeral Director: A	Certification:	3 Suicide 6 4 Homicide	Could not be determined	e	or injury - At n	ome, rami, stre	et, ractory	, onice buil	iaing, etc.	20	or Town,		na Number or F	Rural Route Num	ber, City
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F 3 F 5	Me	29b. Signature and title					290	c. License r	number			29d. D	ate signed (M	onth, Day, Year)	
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or L	ocation							10d. Inside City Li	mits
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Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other 2002.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		e a	lace of Dispo emetery, crea cbutus	matory or ot	her place		ء 6 –2 7		20c. Locatio			
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,	n		30. Name and address of person who		death (Item	23a) (Type,	Print)	<i>y</i>	tsl	5 1		uni	e Z	21224	
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Please Type or Print in Black Indelible Ink Bernard L. Carter State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June 18, 2006 **Medical Examiner** 0121 hrs e 100 ernaro 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. 8 irthplace (State or **Funeral** Months Days Hours Director 3 216-84 - 2845 1 M 2 F Country) Usual Residence of Decedent 10a. State ì 10b. County 10c. City, Town or Location 10d Inside City Limits Baltimore 1 Yes 2 No or 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Intel. If liem 27 is marked other than "natural", or items 23a or 28a-f sho rother transmatic event, the Medical Examiner must be notified at once. cDirector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rose St 21213 503 US4 13 Was Decedent of Hispanic Origin? (Specify Yes or No. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 8lack, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces; White, etc. 1 Never Married 2 Married Yes Black Widowed 4 Divorced f Yes, Give Year 1 Yes 2 No specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 h Department of Health and Mental Hygene Important: If item 27 is marked other than "nijury or other tranmant ovent, the Medical E College (1-4 or 5+) Denny's Resturant 12+h ishwasher 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Benard L Carter Sr. Be Arnetta gardnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num er, City or Town, State, Zip Code) mother-Seagull Ave Baltimore Md 938 rnetta Lar Date 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Cremation 3 Removal from State 261 06 210N Lansdowne Donation 5 Other Specify Cemeter 22. Name and Address of Facility 21. Signature of Funeral Service Licenses -Harris FUNERU Rd Baltimore Md 21215 Ru the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure List only one cause on each line Between Onset and /Medical Death Heroin intoxication and cocaine use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial - trar Physician/Medical item#1,23a,27,28a-f,perME,g857,7/27/06 TT X UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other 4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Fnd 6/18/2006 | Found at nooh 1 Yes 2 X No death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 603 N. Rose Street Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be within 24 hours at To the Funeral D determined (Specify) found at residence 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 18, 2006 30. Name and appress of person ho completed cause of death (Item 23a) Deputy Chief Medical Examiner Ripple MD. 111 Penn Street, Baltimore, MD 21201 Mary G Registrar's Signatur Day, Year) 2006 State

Registrar

JUN 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Chrisman 20 2006 18 OS sharon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Buttinore CIA
If Under 1 Year | If Under 24 Hrs. |
Hours | Min. | Johns Hoplans Hospital Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF 63 Yrs. 60 248 MARYLAND Director 1942 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Iteme 23a or 28a-f show empty injury or other treumatic event, the Madical Examinar must be notified at ODE. 1 Yes 2 No CARROLL WESTMIN STER Directo mo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code SYKESVILLE 21157 5242 Rocur USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry UNION LOCAL 1501 Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASST. IBEW 0 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be PATRICK DOROTHY ENZABETH COUGNET James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sykesville Road, Westminster, mo 21157 YOUL Chrisman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MEADOW BRANCH CEM 6/26/2006 WESTMINSTER 4 Donation 5 Other (Specify) 22. Name and Address of Facility JN Zum Brun FH & Mov. Co. 21. Signature of Funeral Service Licensee 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. 6028 SYKESVILLE ROWS ELDERSBURG MID 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician days Depsir /Medical Due to (or as a consequence of) Examiner Kulmonan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? the funeral director, page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes ≥ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1'Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined within 24 hours after dea To the Funerel Director completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 TROY RES 000 June 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopking Hospital 600 N waite St Bulto, MO 21287 110 31. Date filed (Month, Day, Year) State JUN 2 2 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item#9, perrH, Caso, 6/22/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 8:551 White Miriam 2006 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sa Ho, If Under 24 Hrs. N/A MD If Under 8. Date of Birth FeD. 7, 1918 5. Social Security Number 9. Birthplace (State or Foreign Country) Indiana 6. Sex 7. Age (In yrs. last birthday) Year **Funeral** 1□M 2 F Days 88 334 - 18 - 8782 Usual Residence of Decedent Director the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "netural", or items 23a or 28e-f sho other traumatic event, the Medical Examinar must be notified at Yes 2□No Baltimor N/A Director 10e. Street end Numbe 10g. Citizen of What Country? death with USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Item eny Injury or other traumatic event, the Medical Examination 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ XNo Specify: Specify: Wh 17 Ď 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City Planner City Government 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daller Bessie Isaac Denman White ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1408 Mount Royal Baltimore, Md. 21217 Mr. Rolf Schmitt/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-22-06 Hilltop Service Co. Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses, 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and state the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 by Physician/Medical use as the attending p 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? tal or Attending...,
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srel Director: After this certificate has be 2/XN0 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: + □Natural 5 ☐ Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

2431 MAZYLAND AVE

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 2 2

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WORETA

ur1)

32. Registrar's Signature

06-04284 Phi

Please Type or Print in Black Indelible Ink

illip Crone		State of Maryland / Department - For State Certificate	of Health and Mental Hy of Death	/giene Reg	No. 2006 1967
Physicia edical Examir	n/ 1	1. Decedent's Name (First, Middle,Last) PHILIP K	CRONE	2. Date of Death Month E June 19, 20	Day Year 3. Time of Death 1326 hrs
- ON BO	4	4a. Facility Name (if not institution, give street and number) Northwest Hospital Center	4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore County
Funeral Director	į	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 X M 2 F 58) If Under 1 Year If Under 24Hrs Months Days Hours Min. Yrs.	8 Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
uny		Usual Residence of Decedent 10c. City, Town or Lo. 10a. State 10b. County 10c. City, Town or Lo.	ocation		10d Inside City Limits
eath with the Maryland items 23a or 28a-f show any ast be notified at once.	Director	10e. Street and Number Deanville	I MORE 10f. Zip Code	109	1 Yes 2 No
th the Ma 23a or 28 notified		2 DANUVILLE COURT APT. 1-A Deauville 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21208 Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	U.S.A. 14. Race - American Indian, Black,
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MD 213 d 2 should b Ith and Men n 27 is mar aumatic eve	2	19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or I		
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Baltimore, permit Pages I an Department of Hee Important: If ite	-	4 Donation 5 Other Specify:	22. Name and Address of Facility	SOL LEVI	NSON & BROS., INC.
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death or After this certificate has been signed by the attending physici Ton the Funeral Director: After this certificate has been signed by the attending physici Ton pleave filled in by the funeral director, page 2 should be detached for use as the burnt	sician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregn Other (Specify)	ancy	23d. Date of delivery Month Day Year
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To To	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		June 20, 2006
HOKPER	1	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 2120	01	L
	State	31 Date filed (Month, Day, Year) 32. Registrar's Signature	South s		
Regi			GINAL	,	

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Physici /Medid Examir Funeral Director	cal .	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number) 5. Social Security Number 6. Sex 7. Age (In yrs.)/ast birthda 260–46–8294 78 Yrs.	4b. City, Town, or Location of Death	ate of Birth onth Day Year 4c. County of D. stee of Birth onth, Pay, Year 9-15-27	26 7 PM
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with the 3a or 28e	I Direc	10e. Street and Number 1330 Laurens Street	10f. Zip Code 21217	10g. Citizen of What USA	Country?
DESILITIOTE; IMETY IGING Z 1 Z 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Ever it were mat be inclifted at once.	by Funeral Director		Nwas Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 □ Yes 2√√2 No Specify:	, etc.) Black, W	merican Indian, hite, etc. Black
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nd 2 sho alth and 1 27 is ma ar treume			illing Address (<i>Street and Number or Rural Rout</i> 330 Laurens Street, Ba		e, Zip Code) 21217
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Dall IIIIOI permit. Pages Department of Important: If it any injury or o			22. Name and Address of Facility March F.H. East	Baltimore, Mo	. 21202
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The lay ate has page 2	Completed	Anatmia		4a. Was an autopsy performed? death	
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To the within 2 To the complet	Me	29b. Signature and title of certifier A sureum Callian.	29c. License number	29d. Date signed (Mo	onth, Day, Year)
<u></u>		30. Name and address of person who completed cause of death (Item 23a) (Typ TASNEEM (ALHANI, 7220 F.	ARE HEIGHTS AVE	E BARTO N	11) 21208
Sta Regist	ate rar	31. Date filed Month, Bay Year 1006 32. Registrar's Signature	de	-/	· J

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 195, 20c per fh/dyr 9856 6-22-06 vt

State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Amend items 10e,19b per fh 8857 de 3006 exth Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day DRYERS 2:31 AM 2006 2018ELT 06 18 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Gilchrist 5. Social Security Number Baltimore TOWSON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days 1 M 2 □ F 69 424-42-6501 Yrs. Aug Alabama Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Md 1 Yes 2 No Baltimore 110WSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **Ecoway** 21286 curt # 2B USA 2011 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Good Samaritan Hospital Security Office 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lou Willie Lee Dryers Mattle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife - Courb # 28 BartiMore Md 21286 JdA M. Dryers 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Oc. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Carrison Forest VA Comptary 6/26/06 twing with No 6/26/06 Dwings 14 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore Md alais 4aun Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) IVER IETASTASES weknow Due to (or as a consequence of): PRIMARY unknown LANCER OF Uskrown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Scother (Specify) HOSPICE 1 Tes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 25643

29d. Date signed (Month, Day, Year)

/18

Pnysician /Medical Examiner signed by the ettending physicien and be detached for use as the buriel-transit The law requires that the death certificate be executed Records, been certificete After death. Director: To the Hospitel within 24 hours e To the Funerel Completely filled in the Funerel Completely filled

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29a. Certifiel

(Check only

29b. Signature and title of certifier

should be detached

page 2

filled in by the funeral director,

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla nent of Health and Mantal Hygene.
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permit. Pages Department of Important; if it eny injury or o

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/ 6601 N. Chaves Street/Balto MD Wendall'R Faulkner MD 32. Registrar's Signature AND ASS

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		•	For State Registrar	State of Maryla		artment of F rtificate of			iene 006 eg. No.	19678
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	/Medic Examin	-0	4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Deat		4c. County of Dea	
	LAGIIII		Doctor's HOs	pital		Lanham			Prince G	eorges
- 67	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year) C	rthplace (State or Foreign country)
*.	Director		239-24-0769 Usual Residence of Decedent	93	Yrs.			03 02	13 No.	rth Carolina
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	calion				10d. Inside City Limits
	Man	tor	MD Prince	e Georges 1	Lanham					t¥∏Yes 2 ☐ No
	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "naturel", or Iteme 23a or 28a-f ehow event, the Madical Examinat must be notified at event.	Director	10e. Street and Number			10f. Zip Code		1	Og. Citizen of Whal C	Country?
	ath w	ral	6934 Storch Cir			20706			USA	
	er de Iteme	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Ever in I	U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puerl	ipecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
36	urs aft	by F	3 ☑ Widowed 4 ☐ Divorced	ed 1 □Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: B1	ack
21215-0036	2 hou	ted	15. Decedent's	s Education	16a. Dece	dent's Usual Occup	ation	duna	16b. Kind of Busines:	s/Industry
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire				
2	lled w tygier her th	S	12th. 17. Father's Name (First, Middle, L	act)	Superv	isor Sur		it ne (First, Middle, M		pital Center
Maryland	d be fi) Be	Unkn				Unkne		nalueri Surrame)	
2	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 ie marked o any injury or other traumatic eve 0002.	으	19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street			City or Town, State,	Zip Code)
Ž	alth ar		Harnetha Ford		6934	Storch C:	ircle, La	anham, MD	. 20706	
ore,	of Head		20a. Method of Disposition	20b.		sition (Name of matory or other place			20c. Location - City o	r Town, State
Ē	Page nent ant: If ury o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Memoval from State	aryland	National	06-2	2-06 La	aurel, MD.	
Baltimore,	permit. Departr Imports any inj		21. Signature of Funeral Service L	icensee					Funeral H	lome
	40 E = 0		Pma	ishall					.C. 20011	
80			23a. Part 1. Enter the disease, or of shock, or heart failure. List of	only one cause on each line.		·			est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			of all	nyrn.	min		
	Examiner			Due to (or as a conse	equence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	iquanta of).					
	ate be executed hysicien end the burial-transit	늗	cause. Enter Underlying Cause (Disease or injury							
~	e exe sien e urial-l	an	that initiated events	с.						
$\tilde{\mathbf{z}}$		Examiner	resulting in death) Last	c. Due to (or as a conse	equence of):					
	physic	cal	that initiated events	c. Due to (or as a conse	equence of):					
x 68760,	certificate t iding physicse as the b	cal	that initiated events resulting in death) Last	d					23d Date of de	Sliver
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Box 6	the death certificate by the ettending physicached for use as the backed for use as the	cal	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d. 23c. If yes, outcome of pregr	nancy tal death 3		,			,
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7	Physici	an	Decedent's Name (First, Middle,							2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	ALMA	DAVIS			45 03.	Taura and a	antine of Dooth	June	13	2006 County of Death	4:50a M
	Examin	er	4a. Facility Name (If not institution, SHADY GROVE ADV)					KVILL	cation of Death			ONTGOME	
	-				ge (In yrs. Ia	st birthday)	If Under		Under 24 Hrs.	8. Date of Birth			place (State or Foreign intry)
	Funeral Director		423-18-6573 Usual Residence of Decedent	1□M 2⊠F	95	Yrs.	Months	Days I	Hours Min.	Dec. 5,	191	0 Alai	oama
	Now I		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	B-f-el	ţ	MD Montgo	omery	Silv	er Sp	ring						1 X Yes 2 □ No
	or 284	ire	10e. Street and Number				10f. Zip	Code		1	0g. Citiz	en of What Cou	intry?
	23a	ai	9601 Burgess La	ine			20	941			J	JSA	
3	De lied within 72 nouts after death with the maryland liat Hygiene. Ad other then "natural", or itema 23a or 28a-f ehow event, the Madical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Deceden Armed Forces d 1 Tyes 2 Tild Yes, Give Year or Dates	i? ⊈No			dent of Hispa offy Cuban, M 212 No S		ecify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: R 1	
	ature ical E	ted	15. Decedent	s Education		16a. Deced	dent's Usua	al Occupatio	n ng most of work	ung.	16b. Kin	d of Business/l	
2000	uu uu uu uu uu uu uu uu uu uu uu uu uu	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	r 5+)	life.	DO NOT us	se retired)	ng most or work	1			
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		8]	19a. Informant's Name/Relationsh B. Joyce Davis		hter		•	ess La		a <i>l Route Number</i> lver Spr	-		
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	Page nent o ant: # ury or		1 StBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	8	Wood	Cemet	ery	6-23-	-2006	Birm	ingham	
3	permit. Pa Departmen important: any injury once.		21. Signature of Funeral Service L	arshal	10	M 4	arsha 217 9	d Address of 111 S th St	Funeral . N.W.	Home, I Washing	nc. ton,	DC 200	011
	nysician /Medical Examiner	0	23a. Pan1 Inter the disease, or shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_aRes	od the death. line.			le of dying, s ire novrhe		or respiratory arre	est,		Approximate Interval Between Onset and Death MINUTE
, y	tificate be executed g physicien and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a conseque	ence of):	VIEN	101010	ngC				3 0 00 7 2
.C. DOY 00	The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mm/ths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal of dea	death 3	Ectopic pr				2:	3d. Date of delin	very Day Year
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Division of vital necolus,	ystcian: The law requir is certificate has been si director, page 2 should	Completed by					·····			24a. Was a autops perform	y ned?	24b. Were aut prior to c death?	opsy findings available omptetion of cause of
2	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						5. Place of Deat	h (Check only on	θ)		
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5	Attending Production of the sector: After the funeral by the funeral control of the funeral	ation:	27. Manner of Death Matural 5 Pending 2 Accident investig		jury Day Year)	28b. Time o Injury	of M	28c. Injury at Work? 1 ☐ Yes	6 2 □ No	28d. Describe ho	w injury	occurred	
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:	3 Suicide 6 Could n 4 Homicide determi	and 286. Place of I	njury - At hon etc. <i>(Specify)</i>	me, farm, sti	reet, factory	y, office		28f. Location (St City or Town		Number or Ru	ral Route Number,
	ne Hospi 124 hou ne Funer letely fill	Medicai	29a. Certifier 1 🔀 Certifyin (Check only one)	Physician: To the best examiner: On the basis and manner:	of examination	vledge, deat on and/or in	h occurred vestigation	at the time, , in my opini	date and place, on, death occur	and due to the cared at the time, d	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)
	Withir To th	Me	29b. Signature and title of certifier				290	c. License n	umber	į.		signed (Month	**
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	6		30. Name and address of person of PO WLIM I NA	Dranenii	9901	Modia	Print)			kville,			
	Q+	ate	31. Date filed (Month, Pays Year)	9 2000 32. R	strar's Signati	ure	W A		JI. KUC	WATTIE,	TILL .	20000	
	Regist		JUN 2	2 2006	ELAZ.	13	Social.	P					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:35 June 20, 2006 Doris Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore Catonsville** Catonsville Commons 8. Date of Birth (Month, Day, Year) 4-26-1919 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours Min. Funeral Months 1 M 200 Maryland 87 219-10-7342 Director Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10b. County if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event. If a Medical Exacting must be multified at 1 ☐ Yes 2 ☐ No Catonsville Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21228 16 Fusting Ave. Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If then 27 is marked other then any injury or other traumment. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 ☒ No Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie E. Rost Norman E. Baldwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 Ewing Drive Reisterstown MD 21136 Nancy Heck, Niece 20b. Place of Disposition (Name of West Arunde! 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 X remation 3 Removal from State 6-22-06 Odenton, MD 4 Donation 5 Other (Specify) Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Sefvice Licen 10 1328 Sulphur Spring Rd., Arbutus, MD 21227 xamel! 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks Aspirate Enysician /Medical Due to (or as a or sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by tild be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 3 ☐ Probably 4 反 Inknown Atrial coincer page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Demento autopsy performed? certificate has 2 No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funeral Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified · Geetra Laya up 197541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD - 21227 4367 Holling Ferry Rd, Svite 4A CREETHA RAJA MD 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

maryland /	Department of Health and Mental H)
	Certificate of Death	

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3. Time of Death

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Funeral Director or 28e-f ahov treumatic avant, the Medical Examiner must be notified at or items 23s Baltimore, Maryland 21215-0036 "natural" of Health and Mental Hygiene.

DAVIS, ROLANI

Department of himportant: If ite any injury or of once. **Physician** /Medical Examiner attending physicien and for use as the burial-transit the Hospitel or Attending Physicien: The law requires that the death certificate be executed this s

Division of Vital Records, P.O. Box 68760,

2. Date of Death **Physician** Roland J. JUNE Davis Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Burnie BAHTIMORE WASHINGTON Medical Center Glen 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex 1**X** M 2□ F Months Days 84 214-12-0359 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 41 McKinsey Road 21146 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer 17. Father's Name (First, Middle, Last) Be Roland M. Davis Anna Bangert 19a. Informant's Name/Relationship (Type, Print) Mrs. Gloria Davis /Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 \ Burial 2 \ Cremation 3 \ Removal from State 4 \ Donation 5 \ Other (Specify)
21. Signature 1 - uperal ervir. June 26, Parkwood Cem.Co. 2006 401411 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebro UASCUlAR Achident Due to (or as a consequence of) Sequentially list conditions, if any, loading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a societywenes of) Examine Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24a. Was an perform 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death [Check only one] Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director:. completely filled in by the i 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number D027415 June 19,200 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HENRY Francis MP. BAHimore Washimton Medical Center 32. Hellistrar's Signature State

2006 4c. County of Death Anne Alundel Hours Min. 8. Date of Birth (Month Day, Year) Dec. 30, 1921 Birthplace (State or Foreign Country) 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Westinghouse 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 McKinsey Road Severna Park MD 21146 20c. Location - City or Town, State Baltimore, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the discontinuation of the death occurred at the time, date and place, and due to the cause(s) and manner stated.

[In the discontinuation of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Registrar

death

			1 - For State Registrar	State of Marylar			nt of Health <i>te of Dea</i> i		lental Hy	giene Reg. No	400	6	19682
ı	Physici		1. Decedent's Name (First, Middle, Last) Esther E.		_				2. Date of De	Da	y Year	r	Time of Death 5,13aM
	/Medic Examin Funeral Director		5. Social Security Number 198-24-5297 Usual Residence of Decedent	1970 HOSP 7. Age (in Irs. 75	Yrs.) If Und Months		ale der 24 Hrs.	8. Date of Big (Month, Da Aug. 4	4c	County of De	titholace	MOTE (State or Foreign /Ivania
	Marylan -f ehow	tor	10a. State 10b. County Md Baltimor	· ·	ity, Town or L Baltimo								nside City Limits
	th with the 23a or 28a	ai Director	10e. Street and Number 8810 Walther Blvd	. #2313			ip Code 21234			10g. Cit	izen of What (Country?	1
036	urs after dea el', or items Execution in	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13.	Was Dec If Yes, sp	edent of Hispanic ecity Cuban, Mexi 2X No Spec		ecify Yes or No Rican, etc.))-	14. Race - An Black, Wh Specify: W	nite, etc.	idian,
1215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or items 23a or 28a-f ehow event, the Medical Examinational templied at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	edent's Us e kind of w DO NOT	ual Occupation ork done during m use retired)	nost of work	ing		ind of Busines		,
Maryland 2	e da ta be	Be	17. Father's Name (First, Middle, Last) Arthur	Faas		10.10			e (First, Middle			леро.	
Maryl	12 should h and Men 7 Is marke traumatic	卢	19a. Informant's Name/Relationship (Ty) Mr. Fred Diehl/ So	pe, Print)			ss (Street and Nur ter Lane	nber or Run	al Route Numb				ө)
ore,	Pages 1 and 2 should nent of Health and Men int: if Item 27 Is marke iry or other traumatic		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Disp cemetery, cre	osition (Na ematory or	ame of other place)	The same of the sa	Date	20c. Lo	ocation - City of WSON , M	or Town, S	State
Haiti	permit. Page Department Important: Il any injury o		21. Signature of Funeral/Service License		2	2. Name a RUC 105	nd Address of Fa K TOWSON O York R	Funer d Tox	al Homo	e, I	nc. 1204		
	https://www.dicate be executed by sicion and https://www.dicate.com/wisi-transit to burial-transit to	edical Examiner	23a. Part1. Enter the disease, or compfit shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cations that caused the dealer cause on each line. Due to (or as a consect to the consect to th	quence of):	is		as cardiac	or respiratory a	rrest,		Inte	roximate rival Between ret and Death day 5
O. BOX 6	ath certif ittending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3	⊒Ectopic p □ Other (s					23d. Date of de Month	elivery Day	Year
ds, P.	tuires that the de n signed by the a lid be detached f	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	underlying	cause given in Pa	ırt I.			use contribute		use of death?
Vital Records,		Completed							24a. Was autor perfo 1 \(\text{Yes} \)	osy rmed?	death?		indings available ion of cause of
\ <u>\</u>	ysicien is certifii director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 10	ospital: 1 1 patient 2] ER/Outpatie	nt 3□ D	04		n <i>Ch</i> eck only o		C (10th (0		
ion of	ing Ph		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at Work?		28d. Describe I			эсігу)	
DIVISION	e Hospital or Attenc 24 hours after death Eunerel Director: etely filled in by the i	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, st	reet, facto	ry, office		28f. Location (S City or Tox	Street an vn, State	d Number or F)	lural Rou	te Number,
	To the Hospital within 24 hours a To the Funerel C completely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, deal ation and/or in	th occurred evestigation	d at the time, date n, in my opinion, d	and place, death occurr	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. e to the o	cause(s)
)	To t To t	Σ	29b. Signature and title of certifier			29	c. License numbe	250	7	29d. Dat	e signed (Mon	th, Day,	Year)
_	6		30. Name and address of person who co	npleted cause of death (Iter	m 23a) (Type, QUUI i	Print)	mare	Driv	e Bal	tim	ove, N	D.	21237
	Sta Registr		31. Date filed (Month, Day, Year)	32 agistrar's Signa	ature	anti)	V		,		7		

State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 Edgar Ebberts, Jr. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (Innot institution, give street and number) Examiner 154 Himore WDHG N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye NOV 26, 1 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 💢M 2□ F Months 88 216-09-9343 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-1 show If Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic avent, the Medical Engine or must be notified at 1 ☐ Yes 2 ☑ No Director Woodlawn Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6613 Johnnycake Road 21244 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural; or its 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify f Yes, Give Year or Dates: Specify 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Newspaper Elementary/Secondary (0-12) College (1-4or 5+) Newspaper Carrier Delivery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Ebberts, Sr. Alva Ritter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edgar Joseph Ebberts/Son 1136 Incleside Avenue Woodlawn, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: any injury o 6/24/06 *4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Woodlawn, MD 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signatural Funeral Survice Licensee part Edward A. Gregorchik Frederick Road Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (ur as a or Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed2 certificate 2 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 5 Pending within 24 hours after con-1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 \(\tag{Homicide} Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. title of ce License number 29d. Date signed (Month, Dey, Year) 29b. Signature an e of death (Item 23a (Type, Print) 30. Name ar 31. Date filed (Month, Day, Year) State 2 2 2006 Registrar

NAME EDGAR EBBERTS JK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 1:50 PM Walter B. Forney 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death MONE Examiner CAINT AGNES HOSPINAL n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yi Apr. 3, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 215-16-5721 Yrs Director 86 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits rthan "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 ☐ Yes 2 ▼ No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Maiden Choice Lane 21228 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Conductor Railroad n 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be and Mental Walter Forney Mary Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if item 27 is m any njury or other treum once. Health a it. Pages 1 and 2 artment of Health Dolores Costello / Cousin 5304 Brabant Road, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Departion 5 ☐ Other (Specify) New Cathedral Ceme. 6/21/2006 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. of Funeral Service License 21. Signature 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part1. En or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** UNKNOWN /Medical Due to (or as a consequence of) Examiner DIFFUSE ALVEDLAR HEMORATINGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) physicien and the stransit Due to (or as a consequence of) IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ģ in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ADMIC STENDSIS 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed RHEMMATUID AMPHRITIS 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed D V T 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the hours after deal 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P18620 JUNE 16, 2006 30. Name and a cress pf death (1970/234) Typa Print)

ORIGINAL

DO CATON AVE BALTIMONE MANYLAMO 21225.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 2 2006

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21215-0036

Maryland

Baltimore,

P.O. Box 68760.

Division of Vital Records,

			1 - State Registrar	State of Mai	ryland / l	Departme Certifica				giene Reg. No.	2006	19685
	Physicia		1. Decedent's Name (First, Middle, Las	Flord				Clus	2. Date of Dea	Day	Year 2006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. Cit	, Town, or Lo	cation of Death	076	4c.	County of Death	
1	LAUIIIII		Howard Goints	GENERA	- Hos	R 4	Lon	A18		+	lowar	2
	Funeral		5. Social Security Number 6. 5	ex 7. Age	(In yrs. last bii		er 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birt	h	9. Birth	place (State or Foreign
	Director		248-44-6595	□M 2 E F	73	Yrs.	Duys	TOUTS IVIII.	Dec. 13	3, 19	32 Sout	h'Carolina
	p .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Lengtion						10d. Inside City Limits
	anyla ehov	_	,									1 ☐ Yes 2X No
	Ba-f	cto	Maryland Howard		Colum							
	vith th	Directo	10e. Street and Number	T		101. 2	ip Code			•	zen of What Cou	ntry?
	• 234	ra	9036 Moving Wate	12. Was Decedent Ev	en in II C	12 Was Dec	21046	ania Origina (Co	anifu Van ar Na	US	DA 14. Race - Ameri	and Indian
036	be filed within 72 hours after death with the Maryland ital Hygiane. Id other than "natural; or Iteme 23a or 28a-f show event, if a Medical Evarities must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		If Yes, sp		anic Origin? (Sp. Mexican, Puerto Specify:	Rican, etc.)		Black, White,	
Ò	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a	. Decedent's Us	ual Occupation	n ing most of work	ina	16b. Kir	nd of Business/In	dustry
2	thin 7	Pe	Elementary/Secondary (0-12)	College (1-4or 5+)			ing most of work	m'g			
21	gian gian	5	12		P	ostal W	orker			U.S.	Govern	ment
2	al Hygir I other went, II	Be (17. Father's Name (First, Middle, Last)			77		. Mother's Name		_		
<u>a</u>	s should be filed and Mental Hygir Ie marked other sumatic event, II	၉	James	Albert		Houst	on	Hattie	9	Leor	na V	ann
a	2 sho and le m		19a. Informant's Name/Relationship (. ,	Town, State, Zip	ŕ
2	and ealth n 27 ner tr		Kimberley Maffett	-Alsubhi (N								
ore	of H		20a. Method of Disposition 1 Burial 2 Scremation 3	Removal from State		f Disposition (N		7	Date		cation - City or To	
Ě	Pag ment ant: ury c		4 ☐ Donation 5 ☐ Other (Specif		I -	don Par	-	6/21/	06	Balt	imore,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Dapartment of Health and Menta Important: If Item 27 Is marked eny Injury or other traumatic espice.		21. Signature of Funeral Service Licer	nsee			and Address o	110			Funeral MD 2122	
F	Physician		23a. Part 1. Enter the disease, or community of flear failure. List only immediate Cause (Final	one cause on each line		not enter the me					TID 2122	Approximate Interval Between Onset and Death
Ŷ.	/Medical		disease or condition resulting in death)	Due to (or as a	consequence							1 week
	Examiner					,						
		ē	Sequentially list conditions, I any leading to immediate	Due to for as a	consequence	of):						
	ficate be executed physician and is the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
o,	exec an an rial-tr		resulting in death) Last	Due to (or as a	consequence	of):						
68760	ificate be executed physician and as the burial-transit	edical		_ d								
_		ed										
Box	The law requires thet the deeth certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death	3 ☐Ectopic 5 ☐ Other (2	23d. Date of delive Month	ery Day Year
o.	the d	ysle	1 ☐ Yes	9□ Unknown		o 🖂 o o .	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
Δ.	thet I ed by deta		Part II. Other significant conditions of	ontributing to death but	not resulting	n the underlying	cause given in	n Part I.	23e. Did to	obacco u	se contribute to t	he cause of death?
ds	uires sign	D D	RENSL FAIL	UNE -					1 🗆 Y	es 2	No 3 Prot	oably 4 Unknown
Š	w requir been si should	ete	DEMENTIA	. ,					24a. Was	•		opsy findings available
ğ	Physician: The lavithis certificata has al director, paga 2	Completed by	CHENTIA						autop		prior to co	impletion of cause of
a			CHT			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1 Yes	28 No	1 🗆 Yes	2 No
⋚	siciai certii recto	Be	25. Was case referred to medical examiner?	Hospital:			Other	6. Place of Deatl				
Division of Vital Records,	Attending Physician: It death. ector: After this certification in the funeral director.	To	1 Yes 2 No	Inpatient		utpatient 3 0	JUA		me 5 Resident		Other (Specif	(y)
L C	ding After	E I	1 atural 5 ☐ Pending	28a. Date of Injury (Month, Day	Yeer)	Injury M	28c. Injury at Work?	2 🗆 No	200. 2000		33341134	
<u>s</u>	deati deati ctor: / the	Cal	3 Suicide 6 Could not b		v - At home fa				28f Location /5	Street and	d Number or Rura	al Route Number
<u>≥</u>	l or A efter Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	2, 51.551, 1451	y, onice		City or Tox			a riodio ridinadi,
_	lospital hours e uneral	C	29a. Certifier Certifying Ph	ysician: To the best of	my knowledo	e, death occurre	d at the time	date and place	and due to the	cause(s)	and manner as s	tated.
	I 4 II a	edical	(Check only 2 Medical Examone)	niner: On the basis of e	examination ar	nd/or investigation	n, in my opinio	on, death occur	red at the time,	date and	place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	\		2	9c. License nu	umber		29d. Date	signed (Month,	Day, Year)
	- 5-0		1 Jan 19	-V/~ 1	MC		N/-	0469		6	17.1	16
•	ON		30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Print)	1) 60	7 6 7		0	, , (
1	^		30. Name and address of person who	. 5	7058		5755	ceon	rala.	Z	Colun	dM aidu
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		7''				~	-20014	V 21
	Registr		IIIN 2 2 :	2005	2a	1						

			For State	State of Marylar				Mental Hy	gienę	2006	19686
	_		Registrar 1. Decedent's Name (First, Middle, La:	-41	(Certificate of	Death	2. Date of De	Reg. No.		3. Time of Death
п	Physicia	an	A 1.	•				Month	Day	- 4	2344 M
6.	/Medic	- 10	Alice Gain 4a. Facility Name (If not institution, giv.)			4b. City. Town, o	r Location of Death	June	4c.	O 6 County of Death	
	Examin	er	University of Mary		enter	0	nore			N	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs		day) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birth	nplace (State or Foreign untry)
	Director		215-24-2895	□M 2 / (F	18 Y	s. Months Days	Hours Min.	OCT, 1	6,190	27 M	ARVLAND
-	P.		Usual Residence of Decedent	100 0	h. Toum	or Location			7		10d. Inside City Limits
	anylau ehow	_	10a. State 10b. County	1/4	ty, rown			- n.	-1		1 X Yes 2 No
	Ne M	ecto	MAKYLAWO / 10e, Street and Number	V/A		10f. Zip Code	TIMOR	(E C/	100 Citi	izen of What Co	
	with t	눕	(34/3/ /.)	7 a Taul Au	ENU		1100	0	10 g . Oiti	//<	only:
	ns 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U		13. Was Decedent of H If Yes, specify Cuba	Iispanic Origin? (Si	pecify Yes or No	0-	14. Race - Amer	
10	filed within 72 hours after death with the Maryland Hygiene. ther then "natural; or Items 23e or 28e-f ehow ent, the Medical Examinational be notified at	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ANo				o Rican, etc.)		Black, White	o, etc.
5-0036	ours a	by	3	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:			Specify:	LACK
2-0	72 hc	Completed	15. Decedent's En (Specify only highest gra	ducation ade completed)	16a. [ecedent's Usual Occup Give kind of work done ife. DO NOT use retired	ation during most of wor	king	16b. Ki	ind of Business/I	ndustry
7	ithin 1000 M	ηpi	Elementary/Secondary (0-12)	College (1-4or 5+)	1	1			0	11/1	Lange
2	tygier her ti	S	9 HH GRADE 17. Father's Name (First, Middle, Last,)	/	TOMEM	18. Mother's Nan		Maiden	Sumame)	TOME
and	d be d of or or or or or or or or or or or or or	Be	PETER	THO	m C	Soul	10111	5 F	,	HAI	1001/
Maryland	hould d Me mark matic	2	19a. Informant's Name/Relationship (-	Mailing Address (Street	and Number or Ru	ral Route Numb	er. City o	r Town, State, Z	ip Code)
<u>B</u>	od 2 s Ith an 27 io 1 treu			EBORO (DAUGHTER	1/2		000 ST.	BATO	MI	. 21:	229
ē,	Hea Hea Hea Hea Othe		20a. Method of Disposition	20b.	Place of (Disposition (Name of crematory or other place	/	Date	20c. Lo	ocation - City or 1	Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show simply or other treumatic event, the Medical Examination and Examination and DDGs.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donatjon 5 ☐ Other (Specil	IRemoval from State	,			26-06	11)0	ODIANI	MARVIANA
Ħ	mit. Deartm	- 1	21. Signature of Funeral Service Lige		1	22. Name and Addre	ss of Facility R	241121	TP 1	FUNER	di HomE
m	Depermine Depermine on the procession of the pro		I Can I). 10m)	2140 N	FULTO	JAVE.	BAL	10. MD	MARYLAND AL HOME 21217
y6	""		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do no	t enter the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Interval Between
	Physician		Immediate Cause (Final disease or condition	· Non-ST	F10	wation M	vacand	in I Tw	fore	tion	Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	quence of):	y ocar a	CO(1)	1101	2110/1	
	Examiner		Sequentially list conditions,	b							
11	/B #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):					
V	end end -tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	nuence of	١٠				_	
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68760,	es that the death certificate be executed igned by the attending physicien end be detached for use as the buriat-transit	edical		d							_
•	certif nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		-				23d. Date of deli	very
Box	death a atter	clar	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	y 			Month	Day Year
P. O.	t the c by the achec	Physician/M	9 Unknown	9□ Unknown							
	s that	by P	Part II. Dther significant conditions	contributing to death but not re	sulting in	he underlying cause giv	ven in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
ğ	w require been sig should b							1 🗆	Yes 2	ØNo 3□Pro	bably 4 Unknown
၁၁	e law re has be je 2 sho	piet						24a. Was		24b. Were au	topsy findings available ompletion of cause of
Ě	The ate har page	Completed							ormed?	death?	2 12 No
Vital Records,	strific ettor,	Be (25. Was case referred to medical examiner?				26. Place of Dea				
of	hysi this c	မ	1 Yes 2 No		ER/Out		1er: 4 ☐ Nursing H				uty)
Ē	After unera	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Ti	ury Wo		28d. Describe	how injur	y occurred	
Sic	death death tor: ,	icat	2 Accident investigatio 3 Suicide 6 Could not b	10	lomo for		Yes 2 No	29f Location	(Street an	d Number of Ou	ral Route Number,
Division	or A after Direc	ertification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		ii, street, ractory, onice		City or To			rai noute ivaniber,
_	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	O	29a. Certifier 1 Certifying Pl	nysician: To the best of my kn	owledge	death occurred at the te	me, date and place	, and due to the	cause(s)	and manner as	stated.
	e Hos	edicai	(Check only 2 Medical Examone)	miner: On the basis of examin and manner stated.	ation and	or investigation, in my o	ppinion, death occu	rred at the time.	, date and	place, and due	to the cause(s)
	withir To th	Me	29b. Signature and title of certifier	1	_	29c. Licens	_		£	te signed (Month	- /
			James &	- m.O.,1	Ph. L	P. P19	836		ں لے	ne 19	06
_	2		30. Note and address of person who	completed cause of death (Ite	m 23a) (1	vpe. Print)	-				
_	0		Jomes Strait,	22 S. Green	e St	Baltim	ore, Mr	1,212	.01		
136	Sta		31. Date filed (Month, Day, Year)	32 gegistrar's Sign	ature	And.					
30	Regist	rar	JUN 2 2 2	JUO SERVEN -	RF.	STORES S					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** HELMA GODWIN 30PM 2006 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HARBOR (EN TER OSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) **Funeral** 128-14-8786 1 M 2 F Director March Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23s or 28s-f ehow the Modical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 230 Funerai Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Tes 2 100 Baltimore, Maryland 21215-0036 Blac þ Specify: 8 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (#-4or 5+) Museug 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Sumame, Be Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, _doute Fitchest 49 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Qurial 2. Cremation 3 Removal from State Department of Important: If any Injury or once. 4 Donation 5 Other (Specify) 21. Signature Funera Service Lige 22. Name and Address of Facility Approximate Interval Between Onset and Death er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE **Physician** HEART HAILURE 24 hours /Medical Examiner ATHEROSCLEROTIC CARDIOVASCULAR DISEASE HYPERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sete hes been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1△Yes 2□ No autopsy performed After this certificete 2 No or Attending Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. investigation 1 TYes 2 □No 2 Accident Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗍 Homicide To the Hospital o within 24 hours off To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 MD 2006 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XIAOGUANG 3001 S HANOVER STREET, BALTIMORE, MD 21 225 31. Date filed (Month, Day, Year) 32 aistrar's Signature State 2006 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7,451 raci 13,2006 /Medical 4b. City, Town or Location of Death 4c. County of Death 4a. Facility Name (It not institution, give street and number) Examiner etemore Months Days Hours Min. (Month, Day, Year)

AV 3 126,1943 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 037 212-42-1 XM 2 ☐ F **Director** Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location If item 27 is marked other then "natural", or iteme 23a or 28e-f show or other traumatic event, the Madical Exemples must be notified at 1 Nes 2 □ No Director ma 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16 Funeral Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 □ No 1963 IYes Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 Z No Black 1966 Specify: ģ 4 Divorced 3 Widowed Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education Watkin and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) OFFICER NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy importent: If Item 27 is marked other y injury or other traumatic event 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son mallardC 8908 olumbia, ma, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21-06 Owing mil Forest 22. Name and Address of Facility 21. Signature FredHILT on Balto md. 21229 march Freneral Home not be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final Tetastatic NON **Physician** Month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ate has been signed by the attending physicien and pege 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Tyes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 2 ER/Outpatient Certification: To 1 ☐ Yes 2 No 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Iniury 1 Natural 5 Pending 1 ☐ Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 153 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

22. Registrar's Signature
ORIGINAL

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	Regi				Cert	tificate o	f Death		,,,	Reg.	No.	200	5 1968
Physicia ledical Examin	er	- 1	ary		het	. ,	Gree.		Jui	ite of Death onth E ne 17, 20	_	Year	3. Time of Death 0820 hrs
)		Facility Name (if not in 730 Frederick Ro		eet and number)			4b. City, Town, Catonsvill	or Location of Dea e	ath			unty of Death more Cou	
Funeral Director	21,	S-SG-00/0			(In yrs la:	st birthday) Yrs		ear If Under 24H ays Hours Mi		Pate of Birth (E	hplace (State or n untry) Md.
daryland 28a-f show any i at once.	10a.	al Residence of Deced State 10b. C		rore	10c. City, 1	Town or Locat	ato.	neu, lle	<u></u>				10d. Inside City Limits 1 Yes 2 No
th the Mary 23a or 28a notified at	o l	Street and Number	Wir	ters	La		10f. Zip Code	1228		10g	Citizen	of What Coun	try?
0	oy Fune	Marital Status Never Married 2 Widowed 4	Married 1	es, Give Year Dates:	No	1	es, specify Cub		to Rican	, etc.)	Spec	White, etc.	Slack
5-0036 lled within 72 hours Hygiene other than "natu the Medical Exan	mpleted	Decedent's Education lementary/Secondary	(0-12)	College (1-4 or 5	+)	16a Deceden during m	ost of working I	pation (Give kind of ife. DO NOT use re	etired)	P.	F	Of Business/Ir JOD Fruite	chain estry
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	ည် ^{17. န}	Father's Name (First, M	Middle, Last)	20				18 Mother's Nam	ne (First,		0	name) Res	
O de braia		Informant's Name/Rel		Print) -dau	other	19b. Mailing	Address (Str St.Pa	eet and Number or		oute Numbe	r, City or	Town, State,	Zip Code) 2 / 202
or Heal				Removal from Stat	te cr	ace of Dispos ematory or oth	ition (Name of oner place)	Cemetery,	Date 24	4-06/	Oc. Local	tion - City or T	own, State
Baltimo permit Pag Department Important: injury or ot	21. 8	Signat of Fune = S				22. N	lame and Addre	ess of Facility 2	70 F	Sed H	HODE	n Pa	es Lto, mol, 2/22
Physician /Medical		Party Put of the disease and the List only one late Cause (Final disease)	cause on each li	ons that caused t ne. .conol and		Do not enter th	ne mode of dyin	g, such as cardiac	or respir	ratory arrest,	shock, o	or heart	Approximate Interval Between Onset and Death
xaminer		ondition resulting in de	14.5	to (or as a conse			OXICACIO						
	if an	uentially list conditions by, leading to immediat se Enter Underlying (e Due Cause	to (or as a conse	quence of):								
		ease or injury that initi nts resulting in death)		to (or as a conse	quence of):								01
3760, filtcate be executed by physician and so the burial - transi	X eq	UNPENDED		item#1		7,28a-f,	perME,g85	8,8/7/06 T	Т				
Box 68760, e death ccrtificate by the attending physic ed for use as the bur	23b.	EMALE: Was decedent pregna past 12 months? Yes 2 No 9	at in the	3c. If yes, outcom Live birth Pregnant at t		2 Fe	tal death 3 her (Specify)	Ectopic pregn	nancy		23d Dat	te of delivery th Da	ay Year
P.O. Es that the congression of detached	<u></u>	II. Other significant o		THE RESERVE THE STREET	but not res	sulting in the u	inderlying cause	given in Part I.					ne cause of death?
of Vital Records, ng Physician: The law require of the this certificate has been si meral director, page 2 should the	Completed					···			24	4a Was an autopsy		prior to co	ppsy findings available mpletion of cause of
tal Rec	5 25 1	Was case referred to m	lezibac				26 Pla	on of Dooth (Charle		performe ✓ Yes 2	d? No	death? 1 ✔ Yes	2 No
Vital hysician this certal director	စို ပ	examiner? 1 • Yes 2 N	Hospi	i inpution		R/Outpatient		Other Nursi	ing Home		sidence	6 Other:	Scene
on of ending P ath. or: After the funera	27. N	Manner of Death Natural 5	Pending	28a. Date of Injury (Month, Day, Ye Fnd 6/17/		286. Time of Ir unk	· ·	jury at Work? Yes 2 Y No		escribe how	injury oc	curred	
Division ital or Attendia urs after death. ral Director: A	Certification:	Accident Suicide 6 X Homicide	Investigation Could not be determined	28e. Place of Inju		ne, farm, stree			28f. Lo	ocation (Stre) /30	umber or Rura Frederi	al Route Number, City ck Road
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	29a.	Certifier 1 Certify	al Examiner:On	To the best of my the basis of exam manner stated	knowledge ination and	e, death occur d/or investigat	red at the time, ion, in my opinio	date and place, and on, death occurred	d due to	the cause(s) and mar	nner as starte	d cause(s)
F 3 F 8	29b.	Signature and title of		mariner stated	_			nse number		29	9d. Date s	signed (Mont	h, Day, Year)
offerd	30. N	Name and address of p	44	Uffull leted cause of de	ath (Item 2	?3a)	0.0	C.M.E. 		J	une 18	, 2006	
pe	N	Margarita Korell N	MD. Assist	ant Medical E	Examine	r 111 Pe	enn Street,	Baltimore, MD	21201				
Sta Registr		Date filed (Month, Day,	^{Year)} 2006	32 degistrar	s Signature	Spare	Ke						

		1 = For State Registrar	State of Mai	ylaii		ertificate of			orritar i i y	Reg. No.	2000	1000
Physic	ian	1. Decedent's Name (First, Middle,							2. Date of De Month	Day	Year	3. Time of Death
/Medi		ARTHUR ROBERT							JUNE		2006	10:19 P
Exami	ner	4a. Facility Name (If not institution, ST. JOSEPH MEI				4b. City, Town, C		n of Death			County of Death	F
Function				in yrs. i	ast birthda			er 24 Hrs.	8. Date of Bi			
Funeral Director		212-28-3991 Usual Residence of Decedent	11 M 2□F	78_	Yrs	Months Davs	Hour	s Min.	8. Date of Bi (Month, D. 8/24/	1927	MAR	place (State or Foreigntry) YLAND
aryland show		10a. State 10b. County	1	Oc. City	, Town or	Location					1.	10d. Inside City Limit
Mary Ind	ţ	MD BALTI	MORE		TC	WSON						1 ☐ Yes 2 🔀 No
ith the Me or 28a-1	ired	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Cou	ntry?
ath wi	rai	6713 LOCH RAVEN	BLVD.			2123					USA	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-f show other treumatic event, the Marical Examiner must be notilised at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	If Yes, Give	erin U. WWI:		3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No			cify Yes or No lican, etc.)		4. Race - Americ Black, White, Specify: WH	
72 ho	eted	15. Decedent's (Specify only highest			16a. De	cedent's Usual Occup ve kind of work done	pation during m	ost of workin	a		d of Business/In	
Par set in 121	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		TRAN	ve kind of work done . DO NOT use retire SFER	nd)				RMACEUTI PPLY	CALS
12.		9TH GRADE 17. Father's Name (First, Middle, L.	ast)		F	HARMACEUT:		Sther's Name	/First Middle			
Maryland 2 d 2 should be filed th and Mental Hygi t7 is marked other treumatic evant, 1	o Be	ARTHUR FREDERI	•				I	TELLA I	•		Surramey	
Shoul nd My mark	٩	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Ma	iling Address (Street	and Nun	nber or Rural	Route Numb	er, City or	Town, State, Zip	Code)
Malth ar alth ar 27 is		EMMA H. GNAU/WI				3 LOCH RA	VEN I	BLVD.	TOWSO	N, MD	21239	
Ges 1 are of Head		20a. Method of Disposition 1 ☑8uriai 2 ☐ Cremation		20b. P	lace of Dis	position (Name of rematory or other pla VALLEY M	E9VA	Da		20c. Loc	cation - City or To	own, State
altimomit. Pag partment portant: I		4 □Donation 5 □Other (Spe		וטע		DENS		6/24/			EYSVILL	
Baltimore, M permit. Pages 1 and 2 Department of Health important: if item 27 any Injury or other tve		21. Signature of Funeral Service Li	censee			22. Name and Address 8521 LOCH						- 4
		23a. Part1. Enter the disease, or co shock, or heart failure. Vist o	omplications that caused th	e death								Approximate Interval Between
Physician	3 0	Immediate Cause (Final disease or condition				cardia						Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a c				1	11011	Cite	1		
Examinei	L.	Sequentially list conditions.	b. —	Augus	water II.							
V Be ist	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a d	onsequ	ience or):							
60, , o be executed sicien end burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a c	onsequ	uence of):							
68760, criticate be executed by physicien and as the burial-transit	Aedicai I		d									
K 687 entificate ling physie as the l	Med	IF FEMALE:										
Division of Vital Records, P.O. Box To the Hospital or Attending Physicien: The law requires that the death cert within 24 hours efter death. To the Funeral Director: After this certificate hes been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Physician/A	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal	death	B Ectopic pregnanc D Other (specify)	у			23	3d. Date of delive Month	ery Day Year
, P.(y Ph	Part II. Other significant condition	s contributing to death but r	not resu	alting in the	underlying cause giv	ven in Pa	rt I.	23e. Did 1	obacco us	e contribute to the	ne cause of death?
rds, quires (on signe	ed by	Hypertensi	on						12	Yes 2	No 3☐Prob	ably 4 Unknow
Record e law requir	Completed								24a. Was		24b. Were auto	psy findings available mpletion of cause of
The The ete he	ĕ									ormed? 📫	death?	21 No
Vital Fician: The certificate	Be (25. Was case referred to medical examiner?						ace of Death	Check only	опе)		
of \ hysi hysi this c	2	1 Yes 2 No	Hospital:	-	ER/Outpat	IBIT 3LI DUA					Other (Specif	y)
on of Vital Redding Physician: The lath. H.: After this certificate has a funeral director, page 2.	tion:	27. Manner of Death 1 ★Natural 5 → Pending 2 → Accident investiga	28a. Date of Injury (Month, Day Y	ear)	28b. Time Injur	Wo	ryat rk?]Yes 2		3d. Describe	how injury	occurred	
Division of Vital Records, to the Hospital or Attending Physician: The law requires the within 24 hours effer death. To the Funeral Director: Affer this certificate has been signe completely filled in by the funeral director, page 2 should be a	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be Good Blood of Injury	- At ho Specify	me, farm,	street, factory, office		21	Bf. Location (City or To	Street and wn, State)	Number or Rura	d Route Number,
To the Hospital within 24 hours within 24 hours completely filled	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best of remainer: On the basis of examiner: and manner states	caminat	wledge, de tion and/or	ath occurred at the tri investigation, in my o	me, date opinion, d	and place, ar leath occurred	nd due to the d at the time,	cause(s) a	and manner as s place, and due to	tated. the cause(s)
To th Within To th	Me	29b. Signature and title of certifier	0			29c. Licens				29d. Date	signed (Month,	Day, Year)
		> Thomas !	Wilso	2	W	D4	02	77		Jur	ne ZZ	2006
あれ		30. Name and address of person w					~	20 -	7 1 ~ -	20		
	ate	31. Date filed (Month, Day, Year)	Raven Blv			timore	- 1 A	11)	212	27		

DHMH 17 Rev 1/2001

Registrar

			Please	Type or Pri							-			
		1 - For State Registrar		State of M	arylan		artment of lartificate of	Health and I Death	Mental Hy	f.s	006	19	691	
9		Decedent's Name	e (First, Middle, L	ast)				200.77	2. Date of D			3. Time	of Death	
Physici /Medic			Kersel	ey Gates					June 1	.9, 20	06	11:2	2 A ^M	
Examin				ve street and number)	, -		4b. City, Town,	or Location of Death	1	4c. C	ounty of Deat			
<u> </u>		5. Social Security N		venue #210	ne (In vrs. I	ast birthday)	If Under 1 Year	Towson If Under 24 Hrs.	8. Date of B	idh		imore	or Foreign	
Funeral Director		138-28-11		.0	74	Yrs.	Months Days		Oct. 1	6, 19:	31	hplace (State untry) New	York	
pug *		Usual Residence of	Decedent 10b. County		10c City	, Town or Lo	reation							
Maryla	jo	MD	Baltimo	re	Tows							10d. Inside (1 ☐ Ye	s 2 No	
or 28a	irec	10e. Street and Nur			10113	3011	10f. Zip Code			10g. Citize	n of What Co			
23a c	Funeral Director	409 Virgi	nia Aver	nue #210			21286			USA				
items items	une	11. Marital Status	ied 2□ Married	12. Was Decedent Armed Forces? 1 Yes 2/1	Ever in U.	S. 13. 1	Was Decedent of f Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or N o Rican, etc.)	0- 14	Race - Ame Black, White			
ould be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene. Mental Hygiene. And other than "natural; or Items 23s or 28s-f show after event, the Michigal Examinar must be notified at	þ	3 Widowed		If Yes, Give Year or Dates:	NO		1 □ Yes 2 XNo	Specify:		S	pecify: W	ni te		
72 hours "natural"	Completed	(Spec	15. Decedent's E cify only highest g			(Give	dent's Usual Occu	during most of wor	rkina	16b. Kind	of Business/	Industry		
s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. Item 27 ie marked other than "natuu other traumatic event, the Micclean	mpi	Elementary/Seco		College (1-4or	5+)	life. I	/ Book	9d)		Entor	rtainme	nn+		
2 should be filed wi and Mental Hygien ie marked other th aumatic event, the	Be Co	17. Father's Name	(First, Middle, Las	t)		ACTO	/ DOOK	18. Mother's Nan	ne (First, Middle	171		2116		
old be Aental rked rlc ev	To B	Elmer H.	Gates					Barbara	Shaw					
2 should I and Men ie marker aumatic	ľ	19a. Informant's Na						t and Number or Ru						
1 and 2 Health em 27 i		Christoph		mbert / sc			Lancast	er Drive;	Elders					
		1 🔀 Burial 2		Removal from State	CE	emetery, cren	natory or other pla	1			tion - City or			
permit. Page Department of Important: If any injury or ance.		21. Signature of Fu	/		Lake		Name and Addr	Park 6/2 ess of Facility	2/06		sville, 50 York			
			lean U.	ary		Rt	uck Tows	on Funera	1 Home		vson, N)4	
				nplication (that cause y one cause on each I	d the death ine.	. Do not ent	er the mode of dy	ing, such as cardiad	or respiratory	arrest,		Approxima Interval Be	etween	
Physician /Medical		Immediate Cause (disease or condition resulting in death)	(Final on			ascul	av a	cciden	5			Onset and	Death	
Examiner			1	Due to (or as	a consequ	ience of):	lation	Peri	pheral	11400	1 in	18 ma	in ths	
7/12	ner	Sequentially list con if any, leading to im- cause. Enter Under	nditions, nmediate	b. Due to (or as	a consequ	ience of):	10/110.	11		0013(713.			
be executed ician and burial-transit	Examiner	cause. Enter Unde Cause (Disease or that initiated events resulting in death) !		c										
be ex sician burial		,		Due to (or as	a consequ	ience or):								
death certificate be ex e attending physician od for use as the buria	Physician/Medical			d										
th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1□Live birth			Ectopic pregnanc	ev.		230	d. Date of deli			
0 0	ysici	in the past 12 1 ☐ Yes 2 ☑ 9 ☐ Unknown	246	4□Pregnant a 9□ Unknown			Other (specify)				Month	Day	Year	
The law requires that the ate has been signed by the page 2 should be detached.				contributing to death b	out not resu	ılting in the ur	nderlying cause gr	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of	death?	
quires an sign uld be	ed by	Hype	rtente	Noi					1 🗆	Yes 2□i	No 3□Pro	bably 4 🛭	Unknown	
law re as bee 2 sho	Completed	Periph	eral	Vascalo	W	dis	7		24a. Was	san a	24b. Were aut	topsy findings	available	
	Соп	HUPE	erlipi	denia	•	,			auto perf 1 🗌 Yes	ormed? 2 No	death?	ompletion of a	cause or	
Physician: this certific ral director,	Be	25. Was case reference examiner?		Hospital:			0	26. Place of Dea						
Phys arthis aral di	: To	1 Tes 2 2. 27. Manner of Deat		1 ∐ Inpate	iry	ER/Outpatien 28b. Time of	1 JU DON	her: 4 Nursing H	ome 5 Pes 28d. Describe			ify)		
anding ath. or: Aft	atio	1 ☑ Natural 2 ☐ Accident	5 Pending investigation		y Year)	Injury		ork?]Yes 2 □No						
or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined		ury - At hor	me, farm, str	eet, factory, office		28f. Location City or To	(Street and N wn, State)	Number or Ru	ral Route Nur	nber,	
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier	15 Certifying P	hysician: To the best	of my know	ulodas dosth								
e Hos 124 h e Fur	edical		2 Medical Exa	miner: On the basis o and manner st	it examinal:	ion and/or inv	estigation, in my	opinion, death occur	rred at the lime	date and pla	ace, and due	stated. to the cause(s)	
vithir To the	Ň	29b. Signature and	title of certifier	1 MM)		29c. Licen:	se number		29d. Date s	signed (Month	, Day, Year)		
1		PAL	Lecur			-	1000	61487		6/2	41/06)		
'n	i di	30. Name an address	T Al	completed cause of c	death (Item	23a) (Type,	Print) 7600 0.	61485 slev Driv	my suil	e 411,	, Tow	1001/	4/	
Sta	te	31. Date filed (Mon.		32. Rogisti	ar's Signat	Mo	7000	,)	,			1120	Υ	
Registr		E .	JUN 2 2 2		Sur Sh		all							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Deal			eg. No.	6	9692
			1. Decedent's Name (First, Middle, Lest)		Dete of Dea Month		Year 3.	Time of Death
	Physicia /Medic	al	Vergie Holloman	7	06	20 20	06 9	45/AM
	Examin	er	46 1 County Italia (if 110 desiration), give alread one trainedly	ty, Town, or Locat ANDALLS		4c. County	or Deeth GTIMOR	₹E
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 1 Yea		Date of Birth (Month, Day			(Stete or Foreign
	Director		217-14-5651 1 M XF 83 Yrs. Months Deys Hould Usual Residence of Decedent		03/24		MARYL	
	Leve Mend	ŀ	10a. State 10b. County 10c. City, Town or Location				10d. Ir	Inside City Limits
	a Men	ţ	MD N/A BALTIMORE CITY					1 X Yes 2 □ No
4	deeth with the Meryland THE 236 or 286-1 show That he notified at	Funeral Director	10e. Street end Number 10f. Zip Code 4803 NORWOOD AVENUE 21207		1	0g. Citizen of W	-	
9500	urs ener deer al', or Nerne : Examiner mu	þ	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Merried 3 X Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, Sive Year or Dates: 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexify Yes, Give Year or Dates:		y Yes or No- an, etc.)	Blac	e - American In k, White, etc.	
o i	natur	eted	15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during n life. Do NOT use retired)	most of working		16b. Kind of Bu	siness/Industr	у
V	then the	Completed	Elementary/Secondery (0-12) College (1-4or 5+) 1 2 TH College (1-4or 5+) MISSIONARY			RELIGI	ous o	UTREACH
0 :	other other	Be C	17. Father's Neme (First, Middle, Last) 18. Mo	Mother's Name (F			e)	
yian	Mente Mente Britch of Brit	2		DELZIN				
Mar	h end h end 7 ie m traum	1	19a. Informant's Name/Relationship (Type, Print) MILDRED F. JEFFERSON / SISTER 4803 NORW					
1	f Heelt fem 2 other	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of		-	20c. Location ·		
	tment of tent: If i		4 □ Donation 5 □ Other (Specify) WOODLAWN CEMETERY		24/06		MORE	
Dai	Depermination important		21. Signature of Fotheral Service Licensee 22. Name and Address of Fa	. UOM				RE, MD
	Physician		23a. Pet Cent the dise e, or complications that caused the deeth o not enter the mode of dying, such shoot, or heart failled. List only one cause on each line.				Inte Ons	proximate erval Between set and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Carclio bascular Consequence of its purpose	accio	len	I we	itta	
	D #	Je.	Due to (or as a consequence of):	a	ipha	sia	1	5
,	ificate ba executed g physicien and es the buriel-trensit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Due to (or as a consequence of):					
09/89	ate ba physicle the bur	dical	Cause (Disease or injury that initiated events cesulting in death) Last Due to (or as a consequence of):					
	E 00 00	-	d				1	
POX	the deeth cer y the attendir sched for use	icia	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I.	23b. Did to	obacco use cor	tribute to the	cause of death?
5	es thet the deeth cert igned by the attendin be deteched for use	Physician/N			101	es 21 No	3 Probably	y 4 🗆 Unknown
Hecords,	requir been s should	Completed by	,		24a. Wes a		availab	autopsy findings ole prior to etion of cause th?
	The le	E O			NO.	es above	1 □ Ye:	es 2□ No
	clan: ertifice ector,	Be	overnings?	Place of Death (6				
5	or Attending Physician: The lew elter death. Director: After this certificate has In by the funerel director, page 2	on: To	1 Yes 2 No Position 1 Inpatient 2 ER/Outpatient 3 DOA Office. 27. Menner of Death (Month, Dey Year) 1 Natural 5 Pending (Month, Dey Year) 28c. Injury et Work?	rsing Home		ence 6 □Othe ow injury occurr		
DIVISION	ttendir deeth. ctor: Af y the fu	fleatic	2 Accident investigation 3 Suicide 6 Could mixed experiment to be could mixed. 28e. Place of Injury - At home, farm, street, factory, office			treet and Numb	er or Rurel Ro	oute Number,
5	tai or A rs efter el Directed led in by	Cert	4 Difference building, etc. (Specify)		City or Tow			
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical Certification:	29a. Certifier (Check only one) Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, end menner steted.	ate and place, and n, death occurred	d due to the o et the time, o	ause(s) and ma late and place, a	nner as stated and due to the	i. cause(s)
	vithin 2 vithin 2 To the	Me	29b. Signature and title of certifier 29c. License numb	nber	2	29d. Date signed	Month, Day,	Year)
	4		125 11	12		06/91	1200) b
3		1	30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) TAHOORA HAWATA 20, Crossroads Dr	, Suit	ا 10	NI	N951	7
	Sta Registr		31. Date filed (Month, Day, Year) 32. Refistrer's Signeture					

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da June 20, 200	ay Year	3. Time of Death 0809 hrs
wedical Examin		Haro1d E. Hedrick, Jr. 4a. Facility Name (if not institution, give street and number) 4b. Ci	ty, Town, or Location of Death	June 20, 200	4c. County of Death	
1			Itimore		N/A	
Funeral Director	2	215-56-4629 1XM 2F 57 Yrs. M	Under 1 Year If Under 24Hrs. Days Hours Min.	· ·	MM/DD/YYYY) 9. Birtl Foreign 8, 1949 ^{Cou}	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ž .	5	Maryland N/A Baltimore			~	1 X Yes 2 No
vith the Maryland s 23a or 28a-f show a	Dire	312 S. Furrow St.	Zip Code 21223		Citizen of What Coun	
ter death v ", or item er must bo	Fune	1 X Never Married 2 Married Armed Forces? If Yes, sp	pedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F		14. Race - Americ White, etc.	an Indian, Black,
nours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Use during most of	sual Occupation (Give kind of working life, DO NOT use retire		b. Kind of Business/Ir	dustry
21215-0036 yuld be filed within 72 hours at Mental Hygiene marked other than "natural cevent, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bartend	•		Tavern	
e filed with tal Hygien, sed other nt, the Me	a. I	17. Father's Name (First, Middle, Last) Hazold F Hodrick				·a11
21218 rould be fill d Mental H is marked tic event, t			ress (Street and Number or Re			
Z dath a Z man z m z m z m z m z m z m z m z m z m z	-	Cheryl D. Shook (Sister) 1831 Coo	k Farm Ct., Pa	sandena,	MD. 21122	Fown. State
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		1 X Burial 2 Cremation 3 Removal from State crematory or other pl	ace)		aurel, Mar	
Baltimore permit Pages I Department of I Important: If	Ì	4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name			Funeral H	
	_	23a_Part1 Enter the disease, or complications that caused the death. Do not enter the mo	Wilkens Ave.,	Baltimo respiratory arrest.	re, MD 212	29 Approximate Interval
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a, Atherosclerotic Cardiovascular Disease)			3	Between Onset and Death
Action		or condition resulting in death) Due to (or as a consequence of): b.				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
outed nd transit		events resulting in death) Last Due to (or as a consequence of): d.				
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	a_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal decedent pregnant at time of death 5 Other (eath 3 Ectopic pregnar	псу	23d Date of delivery Month D	ay Y ear
BO ne deat the at hed for	Physici	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the under	thing source given in Dort I	22a Did tohar	cco use contribute to t	he cause of death?
P.O. B es that the de igned by the	ē.	Emphysema	rying cause given in Part I.		2 No 3 Prob	
Vital Records, P.C hysician: The law requires that this certificate has been signed I director, page 2 should be detern.	Completed			24a. Was an autopsy		opsy findings available ompletion of cause of
eco he law ate has	dwo			performe	d? death?	·
ian: T	BeC	25. Was case referred to medical examiner?	26 Place of Death (Check of	only one)		
f Vid Physic er this	မ	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		Home 5 Res 28d Describe how	sidence 6 Other	
on of ending Pt ath. or: After he funeral	tion:	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No		, ,	
Division of Vital Records, tal or Attending Physician: The law require its after death. "In Director: After this certificate has been silled in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, fa	ctory, office building, etc.	28f. Location (Stre or Town, State		al Route Number, City
Division of Vital Rec To the Hospital or Attending Physiciau: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.				
To Too	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mor	th, Day, Year)
		hij hi, mp	O.C.M.E.		June 21, 2006	
100		Name and address of person who completed cause of death (Item 23a) Ling Li, MD	Baltimore, MD 21201			
	tate	11 IN 2 2 /1110 / /////// / / ///// / //////////	Les .			
Regis	પ્રદેશો	A A I I I I I I I I I I I I I I I I I I				

ician	1	1. Decedent's Name (First, Middle, Las	Chris	topher	Carl I	endr X	ix			2. Date of Dea June	Day	2886	3. Time of Deat 5:50p
dical niner	4	4a. Fecility Name (If not institution, give	street and nur	nber)		4b. City,	Town, or	Location of	Death		4c. Cou	nty of Death	
milei	'n	reater Baltimor	e Medi	ical C	enter		Tows	son			B	altim	ore
al		5. Social Security Number 6. Se	ex	7. Age (In yrs.		If Under	1 Year	If Under 2	4 Hrs.	B. Date of Birth (Month, Day	1		lace (State or Fore
or		Unknown 1	∑ M 2□F		Yrs.	Months	Days 3	Hours	MID.	June 8			M D
	-	Usual Residence of Decedent											
		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						,	0d. Inside City Lin
9		MD		0	denton								
Director	1	10e. Street and Number				10f. Zip						of What Cour	ntry?
<u></u>		2249 Commissary				211					USA		
Funeral	1	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U rces?	.S. 13. V	Was Deced f Yes, spec	dent of His cify Cubar	spanic Origi n, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)		Race - Americ Black, White,	
by Fi		1 Never Married 2 Married	1 ∐Yes If Yes, Giv	/e		1 □ Yes	2 ∑ XNo	Specify:			Spe	city: Wh.	ite
d b	-	3 Widowed 4 Divorced	Year or D	ates:	1 40- 0	4	10	**			40h Wind a	4 D	d
Completed	L	15. Decedent's Ed (Specify only highest gra			16a. Deced		rk done d	luring most	of workin	g	160. King 0	f Business/In	austry
E C		Elementary/Secondary (0-12)	College (1	-4or 5+)		Infan					In	fant	
ပိ		17. Father's Name (First, Middle, Last)			1	2.1.2.01.		18. Mother	's Name	(First, Middle,	Maiden Sun	name)	
Be			Hend	ri v						M. Loek			
은		Hugh 19a. Informant's Name/Relationship (1)		LIX	19b. Mailin	a Address	(Street a			Route Numbe		wn. State. Zio	Code)
	- 1	GBMC PATHOLOG			67X	1 1	1	likel	1	treet	Property.	SON /	
	1	20a. Method of Disposytion	1	20b. F	Place of Dispos	sition (Nar	me of		ں درے Da			on - City or To	
	1	1 ☐ Burial 2 remation 3 ☐			DEL N	natory or c	ther place	J.	NF 1	+,2006	_		
одов. To Be Completed by Funeral Director	-	*4 □Donation 5 □ Other (Specify	-	0	MECIV	Name	VIV (s of Facility		Line Line			
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-	+	23a. Part1. Enter the disease, or comp	-Vi-stines that a	accord the deat	h Do not ont	1076	1 }	0.00	(3)			MA	Z L
an al	1	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on e	matur (or as a conseq									Interval Between Onset and Death 4 day.
edicai Examiner		Saquantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to	treme (or as a conseq (or as a conseq	quence of):								4 897
ieted by Physician/Med	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	tcome of pregna birth 2 Feta eant at time of co	aldeath 3	Ectopic pi						Date of delive Month	ery Day Year
무		Part II. Other significant conditions of	ontributing to d	eath but not res	sulting in the ur	nderlying o	ause give	n in Part I.		23e. Did to	bacco use c	ontribute to th	ne cause of death
b A		Sepsis								1 🗆 Y	es 2) No	3 Prob	ably 4 Unkn
Completed		Intrauterine (Srowt	h Ret	orda	Hior	1			24a. Was a	an 24	b. Were auto	psy findings avail
<u> </u>	-	ZITTI GOTCITIC		, , , , , ,	3. J 22.	701				autop	med?	prior to con death?	npletion of cause
ပိ		OS Man area relevant to medical							10 1		25 No	1 U Yes	2 🗆 No
Be	1	25. Was case referred to medical examiner?	Hospital:	0	15B/O 1		Cthe			(Check only or		Oah /O /	
tion: To		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon	-	28b. Time of Injury		28c. Injury Work	4 🗀 Nui:	28	e 5 Resid			//
100		3 Suicide 6 Could not by determined	289. Place	of Injury - At h	iome, farm, stri	eet, factor	y, office		21	Bf. Location (S City or Tow		imber or Rura	l Route Number,
Sertif		29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the b			vestigation	ı, in my op	oinion, death		d at the time, o	date and place	e, and due lo	the cause(s)
edical Certification:								number			and Date sie	nod (Month	
		29b. Signature and title of certifier	TOWN	MO -		1							Day, Year)
Medical Certif		29b. Signature and title of certifier Augela H.	Tau	70 PH	nysicic	1						11-2	

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Hendrix, Boy B. Monico.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 14, Day 006 **Physician** Margaret Ann Holdridge 9:04 a M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Forest Hill 1620 Michelle Court, Apt. A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth OCL. 2, 1955 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex **Funeral** 1□ M 2□F Yrs. 50 218-66-0254 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10h County or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Forest Hill Director Harford Md. 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 U.S.A. 1620 Michelle Court, Apt. A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white Completed by 3 ☐ Widowed 4 € Divorced naturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: if I tem 27 is marked othe eny injury or other traumatic event, 90624. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Rohrback Herbert J. Holdridge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4499 Doncaster Drive, Ellicott City, Md. 21043 Christine Buckley/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 6/19/2006 Baltimore, Md. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIA INFARCTION Physician /Medical Due to (or as a consequence of) Examiner ORONARY RTERI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è 3 Probably 4 □Unknown 1 Yes 2 No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 1☐ Yes 2 X No Division of Vital : After this certifical funeral director, I 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ဥ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification; a or Attending P sefter death. I Director: After t d in by the funera 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 15/06 D5514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air, MD KARL SPECTOR, MIS 2014 TOLLGATE RD, #200. 32 Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 2 2006 Registrar

			For State Registrar	State of M	Marylan		artmen			and M	ental Hy	giene Reg. No.	2006	19696
			Decedent's Name (First, Middle, La	ist)							2. Date of De		Year	3. Time of Death
	Physicia /Medic		Joseph P. Hol	zheid							June	19	12006	725 PM
į	Examin	-	4a. Facility Name (If not institution, gir	e street and number	er)		4b. City,	Town, or	Location o	of Death		4c.	County of Deat	h
		2.	Union Memoria						ore					
	Funeral		,		Age (<i>In yr</i> s. i 95	last birthday) Yrs.	Months	Days	If Under:	Min.	8. Date of Bit (Month, Da	ay, Year)	Co	hplace (State or Foreign ountry)
	Director		214-01-9971 Usuel Residence of Decedent								12-19	-19	10	MD
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	a-fe	Director	MD		Ва	ltimo	re C	ity						1 X Yes 2 No
	or 28	Oire	10e. Street and Number				10f. Zip						zen of What Co	untry?
	eth w	ra	3405 Lake Mont					218					JSA	
	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ XMarried	12. Was Deceder	s?	S. 13.	Was Deced f Yes, spec	ent of Hi ify Cubai	spanic Orig n, Mexican	gin? (Spe i, Puerto F	offy Yes or No Rican, etc.)	D-	 Race - Ame Black, Whit 	
ಕ್ಷ	urs af	by	3 Widowed 4 Divorced	1 XYes 2[If Yes, Give Year or Date:	s:WWT.I		1□Yes 2	2 X No	Specify:				Specify: Wh	ite
2-0036	ilied within 72 hours after deeth with the Maryland Hygiene. Ither then "natural", or Iteme 23a or 28a-f ehow Int, the Medical Examinat mat be multified at	Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Deced	dent's Usua kind of wor	I Occupa	tion	t of works		16b. Kii	nd of Business/	Industry
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	be filed within 7: nal Hygiene. id other then "n event, I'm Medi	S	6			D	rive	r	40.14-15-	1- N	/F: A 4'-1-1-	-		Sales
ב	e d la b	Be	17. Father's Name (First, Middle, Las								(First, Middle t We 1	-	Sumame)	
Maryland	should be and Mental marked of umatic eve	ဥ	John Holzheid 19a. Informant's Name/Relationship			19h Mailir	n Address	(Street a		_			Town State	Zip Code 21218
Σ	s 1 end 2 should f Health and Mer tem 27 te marke other treumatic		Anne Holzheid											more, MD
<u>6</u>	s 1 er f Hea ftem i		20a. Method of Disposition		20b. P	lace of Dispo emetery, crer	sition (Nan	ne of	9)	D	ate	20c. Lo	cation - City or	Town, State
Ë	Pages nent of i		1 ☐ Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Special Control			yview				6-21	-06	Bal	ltimor	e, MD
Baltimore,	permit, Page Department of Importent: If any Injury of once.		21. Signature of Funeral Service Lice	nsee			. Name an		-			Ash	ton Fi	neral Home
n	88559		With Whit	\rightarrow	`	P	A. 2	134	Wil				pad, 2	
i			23a. Part1. Enter the disease, or con shock, or heert failure. List only	plications that cause on each	sed the death n line.								a	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Rein	pinator	Foul	re							2 days
	/Medical Examiner		resulting in death)		as a conseq	dence of):		^						
Ш	LAdillilei	_	Sequentially list conditions,	n Metus	tush c		ate	(au	41					6-wonthy
	bed Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	· Prost		C.								6 years
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last		as a consequ	uence of):						_		GYEAR
/60	ate be executed hysicien and he burial-transit	cail		_ d										
89	rtifical ng phy as th		IC COMM. C			-								
Box	eath certific attending pl	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon 1 ☐ Live birth			Ectopic pr	egnancy				2	23d. Date of del	
	of the dea by the at tached fo	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant 9☐Unknown		eath 5□	Other (sp	ecify)					Month	Day Year
0	The law requires that the death certifica Nie has been signed by the attending ph bage 2 should be detached for use as th	Ph)	Part II. Other significent conditions	contributing to death	h but not resi	ulting in the u	nderlying c	ause aive	n in Part I		23a Did	tobacco u	se contribute to	the cause of death?
Division of Vital Records,	uires thei signed t id be det	d by	Hypertension			3 3	,	3				Yes 2		obably 4 donknown
င္ပ	w require been si should I	ete									24a. Was	an	24h Were au	topsy findings available
ě	he la e has age 2	Completed									auto	psy ormed2	prior to death?	completion of cause of
ta		Be C	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only		1 L Yes	2E No
≥	Attending Physician: The law rideath. c death. ector; After this certificete has t	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	atient 2	ER/Outpatien	it 3□ DO	A Othe	-				Other (Spec	cify)
0	ding Phy h. After thi funeral o		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of In (Month, I	njury Day Yeer)	28b. Time of Injury	2	8c. Injury Work	at	2	8d. Describe	how injury	occurred	
Sign	Attendia death. ctor: A y the fu	catio	2 ☐ Accident investigation	on			М	1 🗆 1	/es 2 □ I	No				
$\frac{2}{5}$	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	289. Place of	Injury - At he etc. (Specify	ome, farm, str v)	eet, factory	, office		2	8f. Location (City or To	Street and wn, State)	d Number or Ru	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu		29a, Certifier 1 Certifying P	hysician: To the be	ist of my kee	wledge doct	0000000	at the sur-	a data a-	d place =	nd due to the	03050/-1	and manners	ctated
	24 hc	Medical	(Check only 2 Medical Exa	miner: On the basis and manner	s of examina	tion and/or in	vestigation,	in my op	inion, dea	th occurre	d at the time,	date and	place, and due	to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	e signed (Monti	h, Day, Year)
			Alush Hles	ny	MD			DO	062	163		Jun	19.2	006
	1041		30. Name and address of person who	completed cause of	of death (Item	23a) (Type,	Print)		-			- 9171	Λ	
	1		Stephen Nouyen	MO, Un	ion Mer	norial	Hospi	tal,	201 Ecis	+ Univ	yrsity Pa	rleway	Bellino	006
	Sta Registi		31. Date filed (Month, Day, Year)	J2. 174501	strar's Signa	ture # A						,		
	negisti	ei .	JUNAA	000	EUR.	Dr B	2344	7						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, perMD, C856,6/22/06 TT

State of Maryland / Department of Health and Mental Hygiene 2 1 1 6

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Mohan Joshi 2. Date of Death 3. Time of Death Month Year JOSHI **Physician** 14:22 PM JUNE 20 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimora
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. N/AHODKINS Hospital ubhns 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) May 13, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1XM 2□F N/A Director India Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "neturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director India N/A New Delhi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code F-II 29 Lajpat Nagar 110024 India Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Specify: Asian Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. 5+ permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Importent: if item 27 is marked other ti any injury or other traumatic event, the once. Lawyer Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mohan Manohar Lal Joshi Parvati Bai Joshi ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Durga Joshi/Wife F-II 29 Laj at Nagar, New Delhi, India 110024 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/21/06 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee Foward A Gregorchik

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 Immediate Cause (Final disease or condition resulting in death) INTRACEREBRAL HEMORRHAGE Priysician DAYS /Medical Examiner 7 DAYS COAGULOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit be executed CIRRHOSIS 13 YEARS Due to (or as a consequence of): Box 68760, Physician/Medical as signed by the attending I be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) Ö 9☐ Unknown 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has t autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 5 To the Hospital within 24 hours a To the Funeral Completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ishiera Gardhi MD RES-000 JUNE 20 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NISHIENA GANDHI, 600 N. WOLFE ST. BALTIMORE, MD 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 2 2006 Registrar

			For State Registrar	State of Ma	arylan	d / Depa	artmer	nt of H	ealth a Death	ind M	lental Hy	/giene Reg. Ne	e ₂ 01	96	9698
	Physici /Medio	al	Decedent's Name (First, Middle, La	KSON . e street and number)					Location of		2. Date of D Month 66	Da / 2	County of		3. Time of Death
	Funeral Director		5. Social Security Number 232–52–9941		e (In yrs. 1	last birthday) Yrs.		r 1 Year	# Under 2 Hours	04 Hrs	8. Date of B (Month, D Feb. 1	eth	934	9. Birthp	olace (State or Foreign ntry) Virginia
	e Maryland la-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor	·e		y, Town or Lo								1	0d. fnside City Limits 1 ☐ Yes 2 ☐ No
	uth with the 23s or 28	Funeral Director	10e. Street and Number 1813 Colonial Roa	d			10f. Zi	Code 21	207			10g. Ci	itizen of W SA	hat Cour	ntry?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Ida Hygiene. Ida chher then "natural", or itema 23a or 28a-f show other then "natural", or itema 23a or 28a-f show event. The Medical Examinar must be notified at	by Funer	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 ff Yes, Give Year or Dates:			Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-		, White,	ean Indian, etc. hite
Maryland 21215-0036	d within 72 ho piene. r then "natur r a Medical	Completed by	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation ide completed) Coflege (1-4or t	5+)	16a. Deced (Give life.	kind of wi DO NOT i	al Occupa ork done d se retired	ation furing most)	of worki	ng		(ind of Bus		dustry
yland ;		To Be C	17. Father's Name (First, Middle, Last, John Barker								(First, Middle Blevins	e, Maidei			
	d 2 sh th and th and 7 is m traum		19a. Informant's Name/Relationship (Cathy J. Jackson			1353	Rol	Ling	Road,	Cat	Onsvil	le,	Mary.	land	21228
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 [X]Cremation 3 □ 4 □ Donation 5 □ Other (Specification		lace of Dispo emetery, crer View (Crema	tory	- 6	5/20	/2006	Bal	ocation - 0	e. M	laryland	
Ba	Deparit Depar Impor any in		2). Strington of Funeral Service Licen	alino		4	107 V	Vilke	ns Av	enue		imor	al Ho	ome, aryla	and 21229
13	Physician /Medical		23a. Part. Shert the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Stysis Due to (or as	ne.		er the mo	ae or ayını	g, such as o	cardiac o	r respiratory :	arrest,			Approximate Interval Between Onset and Death
*	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. PENFO			30W6	-L.							
_	ate be executed hysician and the burial-transit	cal	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):									
Division of Vital Records, P.O. Box 68	The law requires that the death certifical, ate has been signed by the attending phy page 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal	death 3	Ectopic p						23d. Date Mont		ory Day Year
rds, P	w requires that the de been signed by the a should be detached f	ed by Pi	Part II. Other significant conditions of - pmcR Ent I tis	ontributing to death b	uf not resi	ulting in the u	nderlying	cause give	en in Part I.				use contrib		ne cause of death?
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<u> </u>	ician certif rector	Be	25. Was case referred to medical examiner?	Hospitat:				Othe	· ·		(Check only				
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exar	ysician: To the best niner: On the basis o and manner st	f examina	wledge, death tion and/or in	vestigation	n, in my op	pinion, deat	d place, a h occurre	and due to the	, date an	d place, ar	nd due to	the cause(s)
)			29b. Signature and title of certifier	יחי P.				C. License		15					Day, Year)
	10		30. Name and address of person who EDWMCD & LA. 31. Date filed (Month; Day Year) 2 2	completed cause of c	leath (Item	23a) (Type, ECMS	Print)	184.d	2 20	00	BLL	1.	st. 13	net	MD 2/223
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ledical Examin		Erik 4a. Facility Name (if not	t institution, give	David					ocation of E	June 18		c. County of Dea	
		University of M					Baltim	nore				NA	
Funeral Director		5. Social Security Numb 215-94-8024		7. Age	(In yrs, Ias 26	t birthday) Yrs	Month:	s Days	If Under 2 Hours	Min	Birth(MA)	For	Birthplace (State or eign Country) Md .
X	-	Usual Residence of Dec	cedent		10c City T	own or Local	tion						10d. Inside City Limits
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Aaryland 28a-f show 1 at once.	Director	10e. Street and Numbe					10f. Zip	Code			10g. Ci	tizen of What Co	ountry?
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Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumatiniury or other traumatiniury.	ı	20a. Method of Disposi		Domaval from Sto		ace of Dispo ematory or o			etery,	Date	200	. Location - City	or Town, State
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Balt permit. Departi Import		21. Signatur, of Funer	1	nsee			Name and					more, Mo	
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/Medical caminer		failure. List only of Immediate Cause (Fina	al disease a.	Multiple Gunsho	t Wound	ds							Death
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Chack ank)	ertifying Physic edical Examine	r: On the best of m	y knowledg mination an	e, death occi nd/or investig	urred at the ation, in m	e time, da y opinion,	te and plac death occi	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	started. o the cause(s)
To To Cont	Mec	29b. Signature and title		and manner stated.	-			c. License					Month, Day, Year)
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7		30. Name and address		completed cause of of		^{23a)} Penn Stre	et. Balt	imore. I	MD 2120)1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 19, June 2006 Eleftheria Koliofotis 8:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 635 Savage Street Baltimore If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 0 2 - 2 8 - 1 9 4 7 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛱 F Yrs. Director 213-86-5467 59 Greece Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permittent of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel" or the any njury or other traumatic even. 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits Baltimore Yes 2 No MdDirect 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 635 Savage Street 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Simos Dimitriou Vasiliki Spirou 19a. Informant's Name/Relationship (Type, Print) spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dimitrios Koliofotis 635 Savage Street Baltimore Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 06-21-2006 Baltimore Md. ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 2134 Willow Spring Rd. Balti 21. Signature of Funeral Service Licensee Bradley-AShton Funeral Home P. A. Md21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** pheumoinia weer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hepatocallular dans Caurcan metastatio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown hepatitis Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 023809 June 19. Wasle un Lusten

State Registrar DHMH 17 Rev 1/2001 Austra

31. Date filed (Month, Day, Year)

Doyle

JUN 2 2 2006

Division of Vital Records, P.O. Box 68760,

Greenelsaum Cancer Center, 22 S. Croere St.,

Baltmore

mo

21201

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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			1 - For State Registrer				nd / Dep		t of H	ealth a	and M	ental Hy		nne	1970
	· 有	e _ 5	Decedent's Name (First, Midd	le, Last)								2. Date of De			3. Time of Death
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	Examin		4a. Facility Name (If not institution	n, give st	treet and num	ber)		4b. City,	Town, or	Location of	of Death		4c	County of Dea	
2		y .	NATIONAL NAVA			CENTER			BETH					MONTG	
	Funeral		5. Social Security Number	6. Sex	M 2⊠F	7. Age (<i>ln yr</i> s. 55	last birthday, Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th ay, Year)		thplace (State or Foreign ountry)
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	yland		10a. State 10b. County	/			ty, Town or L								10d. Inside City Limits
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	er de İtemi	Funerai	11. Marital Status		2. Was Deced	ces?	I.S. 13.	Was Deced	dent of Hi cify Cuba	spanic Dri n, Mexicar	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.))-	14. Race - Ame Black, Whi	
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	Pages nent of i int: if it		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (moval from S	iaie	cemetery, cre ingtor	-			06/29	/06	Arli	ngton,	VA.
	그 문원들 .		21. Signature of Funeral Service		Э		2	2. Name ar	nd Addres	s of Facilit	y MAr	shall'	s F11	neral H	lome
g	Depared important important in processions in proce		1 QRM	an	shall	2								, D.C.	
	Pnysician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	r complic t only one a.	M	ETAS T A	TIC BR				cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner				Due to (c	or as a consec	quence of):								
Ĕ.	7 / =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) "	Due to (c	or as a consec	quence of):								
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last) c.											
5	cien s		rossiting in south, cast		Due to (c	or as a consec	(uence of):								
0	cate t	dicai		d.											
٥ ٢	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use es the burial-transit	Physician/Medi	IF FEMALE:	23	c. If yes, outc	ome of pregn	ancy							23d. Date of de	livon
2	atten for u	cian	23b. Was decedent pregnant in the past 12 months?		1 Live bir	th 2 Feta	if death 3	Ectopic pi						Month Month	Day Year
j	the d by the ached	hysi	1 ☐ Yes 2 📉No 9 ☐ Unknown		9□ Unknow	wn									
,	s that ned t	by P	Part II. Other significent conditi	ions cont	ributing to dea	ath but not res	sulting in the u	inderlying d	ause give	n in Part I.		23e. Did t	obacco i	se contribute to	the cause of death?
20,0	en sig											10	Yes 2	DXNo 3□Pi	robably 4 Unknown
2	aw re	Completed										24a. Was		24b. Were at	utopsy findings available completion of cause of
	The ate ha	E O										perfo	rmed? 2 X No	death?	2 No
2	cian: ertific ictor,	Be (25. Was case referred to medical examiner?						- +	26. Place	of Death	(Check only			
-	hysion this co	은	1 ☐ Yes 2 🛣 No	Ho		·	ER/Outpatie			4 🔲 Nu				6 □Other (Spe	city)
	After I	inol	27. Manner of Death 1 XNatural 5 ☐ Pendi		28a. Date of (Month	Injury , Day Year)	28b. Time o Injury		8c. Injury Work			8d. Describe	how injui	y occurred	
2	ttend death stor: /	icat	3 Suicide 6 Could	not be	280 Diago	of Injury At h		M		/es 2 □ I		196 Lagation /	Ctroot or	of Alian bases D	10-11
Š	To the Hospitel or Attending Physicien: The law requires that the death within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for completely filled in by the funeral director, page 2.	Certification:	4 Homicide determ	nined	buildin	of Injury - At h g, etc. (Specia	fy)	reet, factory	/, опіс а			City or To			ural Route Number,
	lospita hours unere	edicai (29a. Certifier 1 ☐ Certifyi	ng Physi I Examin	cian: To the t	pest of my kno	owledge, deal	th occurred	at the tim	e, date an	d place, a	and due to the	cause(s)	and manner as	s stated.
	the H sin 24 the F nplete	Medi	one)		and manne	er stated.									
	tive to con	~	29b. Signature and title of certific	er /	7			290	: License	number				e signed (Mont	
	1		Lyndsay	24	ones,	MD			0101	23679					,2006
	Ь		30. Name and address of person					Print)						EDICAL (CENTER
	Sta	to	LINDSAY E. JO 31. Date filed (Month, Day, Year	NES_	LT M	gistrar's Signa	ature	4		BE	THES	DA MD 2	משטוב	7-2000	
	Registr		JUN 2 2		6	CHAI	KA	mark i	7						
DHN	MH 17 Rev 1/20	001				A PART OF THE PROPERTY OF THE PARTY OF THE P	1		·						

DHMH 17 Rev 1/2001

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F		Mental Hy	giene Reg. No.	006	19702
	Physici	an	1. Decedent's Name (First, Middle, Las Joseph Liberto	•				2. Date of Do Month	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give)		or Location of Death	June_		2006 County of Death Norceste	10:20 a M
	Funeral		Social Security Number 6. S		ge (In yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di	rth ay, Year)	9. Birth	olace (State or Foreign
	Director		220-30-6639 Usual Residence of Decedent		/0 Yrs.			Feb 29	193	6 Mary	land
	e Marylan 3a-f ehow tiffed at	ctor	10a. State 10b. County Maryland Worceste	r	10c. City, Town or L Bishopvi						10d. Inside City Limits 1 ☐ Yes 2 X No
	ath with th	rai Director	13285 Rollie Road			10f. Zip Code 21813			Unit	en of What Coul	es
036	72 hours after death with the Maryland Insturat, or Itams 23a or 28a-f ehow disal Exertirat meat be trofffed at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 □ Yes 2 X If Yes, Give Year or Dates:	?	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No p Rican, etc.)		I. Race - Americ Black, White, pecify: Wh	
Maryland 21215-0036	within 72 ho ene. than "natur te Mudical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or	5+) (Give	DO NDT use retire	during most of won	king		of Business/In	•
1d 2	filed Hygi ther	Be Co	17. Father's Name (First, Middle, Last)		Root	ter	18. Mother's Nam	ne (First, Middle		Company umame)	
ylan	could be I Mental parked c	To B	Joseph Liberto,					e Barra			
Mar	d 2 sh th and 7 is m freum		19a. Informant's Name/Relationship (7 Karen Ledford / Di				and Number or Ru is Avenue				
	of Health Item 27	9	20a. Method of Disposition		20b. Place of Disposer			Date		Mal y La Ition - City or To	
Baltimore,	at. Pages artment of ortant: If It njury or o		1 Burial 2 X Cremation 3 4 Doonation 5 Other (Specify)	Bayview	Cremator	У				aryland
Bal	permit. Pag Depurtment Important: any njury o		21. Si nature of Funeral Service Licens	0			ess of Facility Hu				Inc. and 21229
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each	d the death. Do not en					PRILYL	Approximate Interval Between Onset and Death
68760, 4	Medical pe executed ticate be executed by physician and street transit in the burial-transit	dical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Osb.	s a consequence of): ctos a consequence of): s a consequence of):	0	1			-11	7104-
.O. Box	death certi e ettending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	1		23	d. Date of delive	ery Day Year
ds, P	es tha	by	Part II. Other significant conditions co	ontributing to death	but not resulting in the	No.	ren in Part I.		tobacco use Yes 2□		ne cause of death?
of Vital Records,	s been si should	Completed	2) Per. phere	l Vosci	elan Dise			5 6 24a. Was	an	24b. Were auto	psy findings available
- Re		Comp	3) Asbestosis	/COP	D			perfe	psy ormed? 2 No	prior to co death? 1 ☐ Yes	mpletion of cause of 2□ No
Vita	Phyeician: Th this certificate rat director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		ot all post of	26. Place of Dea				
J of	ding Phyen. h. After this funeral di		1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj. (Month, Da	ent 2 ER/Outpatie ury 28b. Time o ay Year) Injury	IL SLI DOA	4 🗆 Nul sing ni	ome 5 Resi 28d. Describe			y)
Division	or Attending tter death. birector: After n by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, st tc. (Specify)	M 1 🗆	Yes 2□No	28f. Location (City or To	Street and I wn, State)	Number or Rura	l Route Number,
u	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best iner: On the basis and manner s	t of my knowledge, deat of examination and/or in tated.	h occurred at the tir	ne, date and place, pinion, death occur	and due to the	cause(s) ar date and pl	nd manner as si lace, and due to	lated. the cause(s)
)	To the within 2 To the complete	Me	29b. Signature and title of certifler	Mrn	шр	29c. Licens	3902		29d. Date :	signed (Month,	Day, Year) 2006.
	2		30. Name and address of person who o	ompleted cause of	death (Item 23a) (Type	Prin" York	53902 = RO, St	e100, l	nuth	ewitte,	MP
e	Sta Registr	_	31. Date filed (Month, Day, Year)	# +.	rar's Signature	-					
DH	MH 17 Rev 1/2	150	JUN 2 2 20	U6 Jan	w H	now!					
					ORIGI	NAL					

				partment of Health and Nertificate of Death		giene 006	19703
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) MARGARET LOU 4a. Facility Name (If not institution, give street and number)	ISE LOKEY 4b. City, Town, or Location of Death	2. Oate of Dea Month June 14	Day Year	3. Time of Death 12:00 P M
	Funeral Director		1514 Boyle Street 5. Social Security Number 214-24-7056 6. Sex 1□M 2X□F 7. Age (In yrs. last birthda, 77 yrs.	Baltimore y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Mar 3,	N/A Year)	nplace (State or Foreign untry) Yland
	he Maryland 18a-f show	Director	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland N/A Baltir	nore			10d. Inside City Limits 1 X Yes 2 ☐ No
	eath with the same or 2		10e. Street and Number 1514 Boyle Street 11. Marital Status 12. Was Decedent Ever in U.S. 13	10f. Zip Code 21230		0g. Citizen of What Cou USA 14. Race - Amer	
-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Ever it artifies at	ed by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	N. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 XI No Specify: Bedent's Usual Occupation		Black, White	hite
Maryland 21215-0036	filed within Hygiene. ther than "	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired) emaker 18. Mother's Nami	ang	Housewife 8	
ırylan	2 should be and Mental is marked o	To Be	Carroll W. White		lizabeth	Anderson	in Code) 10570
	l and lealth im 27		Paul L. Lokey, Jr. (Son) 260	7 West Forest Driv	e, Newpo	ort, North (20c. Location - City or T	Carolina
Baltimore,	permit. Pages : Department of I- Important: If ite any injury or ot		'4 □Donation 5 □ Other (Specify) Md. Vete	eran's Cem. 6/19/ 22 Name and Address of Facility McCully-Polyniak F 237 E. Patapsco Av	uneral H	crownsville	• Maryland
/,0928	death certificate be executed Examine and mand physician and for use as the burial-transit	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on ach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	inius Carrinond	or respiratory arre	951,	Approximate Interval Between Onset and Death
.O. Box 6	death certif e attending ed for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Oate of deliv Month	ery Day Year
rds, P.	sign sign d be		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	oacco use contribute to I	the cause of death?
of Vital Records,	iician: The law requ certificate has been rector, page 2 shoule	e Completed by	Ostechorosis Vertebro Compression Fractus 25. Was case referred to may cal			prior to co death? No 1 Yes	opsy findings available impletion of cause of
Division of Vit	ding Phys h. After this funeral di	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	of 28c. Injury at Work? M 1 □ Yes 2 □ No	me 5 KReside 28d. Describe ho	nce 6 Other (Special winjury occurred	
Σ	pital or Attendous after deatlendous after deatleral Director:		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify) 29a. Certifier Certifying Physicien: To the best of my knowledge, dea	<u> </u>	City or Town		
	To the Hospital or within 24 hours after To the Funeral Director completely filled in It	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or is and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, da	ate and place, and due to the designed (Month,	o the cause(s)
,	5		30. Name and address of person who completed cause of death (Item 23a) (Type	D43623	6	15/06	
	Sta Registr	- 2	31. Date filed (Month, Day, Year) 32. Figistrar's Signature 33. Date filed (Month, Day, Year) 33. Figistrar's Signature	ield hd, Stell, 6	5/en Bo	urnie MD	21061

			For State Registrar	State of Maryland	d / Department of Healt Certificate of Dea		tal Hygien	711116	19704
	Physici /Medio	cal	1. Decedent's Name (First, Middle, La	les	Ab City Town and conti	٨	Date of Death Month Da	4 06	3. Time of Death
*	Examir Funeral Director	ner	4a. Facility Name (If not institution, given the second of	Alalk & HE		der 24 Hrs. 8. D	Date of Birth Month, Day, Year	9. Birth	place (State or Foreign
	put *	or	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		150	114	10d. Inside City Limits 1 XYes 2 □ No
	th with the Marylar 23s or 28s-f show	ai Director	10e. Street and Number	1 Avenue	10f. Zip Code 2/2/7	1	10g. C	itizen of What Cou	<u> </u>
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it a Medical Exandration into the notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	rican, Puerto Ricar	Yes or No- n, etc.)	14. Race - Ameri Black, White,	
21215-0036	a filed within 72 hours il Hygiene. other than "natural", sent, It'e Medical Exa	Completed	15. Decedent's Et (Specify only highest gra Elementary Secgndary (D-12)		16a. Decedent's Usual Occupation (Give kind of work done during r life. DO NOT use retired)	, and the second	16b. F	Kind of Business/Ir	
Maryland 2	should be filed and Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Richard Cy	1/es	18. M	other's Name (Firs	e Cu	rbea	N
	s 1 and 2 sho if Health and Item 27 is my other traum		19a. Informant's Name/Relationship	Mason 206. Pla	19b. Mailing Address (Street and Nu. O S Howley ice of Disposition (Name of metery, crematory or other place)	Date	Balto,	or Town, State, Zij MD 2 ocation - City or Ti	1217
Baltimore,	permit. Pages Department of I Important: If Ite any injury or of		1 ☐ Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 1) ☐	(re	enmant Cremab	19 6/19	106 B	Servi	1D
	Physician /Medical		23a. Part1. Enter he disease, o commo shock, or heart failure. List only fmmediate Cause (Final disease or condition resulting in death)	blications that caused the death. one cause on each line. Due to (or as a consequence)	e myeloge	Stricks as cardiac or response	piratory arrest, Leuke	ma	Approximate fnterval Between Onset and Death
8760,	ate be executed ysicien and he burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque d.	ence of):				
P.O. Box 68	The law requires that the death certificate at the been signed by the attending physbage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome of pregnan 1 Live birth 2 Fetal c 4 Pregnant at time of dea	death 3 Ectopic pregnancy			23d. Date of delive	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions of		ting in the underlying cause given in Pa	art I. 2	23e. Did tobacco 1 ☐ Yes 2		he cause of death? pably 4 Munknown
Division of Vital Records,	ician: The law i certificate has bi rector, page 2 sh	Completed	25. Was agas relayed to madical			1	24a. Was an autopsy performed?	prior to co death?	ppsy findings available mpletion of cause of 2 No
Ξ	eician: s certific lirector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ E	7 04	face of Death Che		. Ca	
ı of	ig Phye ter this neral di	n: To	27. Manner of Death		28b. Time of 28c. Injury at		5 ∐ Residence Describe how in i u	6 ☐Other (Specifing occurred	y)
jo	ath. or: After or: After	atio	1 ∰Naturaf 5 ☐ Pending 2 ☐ Accident investigation		Injury Work? M 1 ☐ Yes 2	! □No			
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p.	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify)	ne, farm, street, factory, office		lity or Town, State		
	Mosp 24 hor Fune etely fi	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my know niner: On the basis of examination and manner stated.	ledge, death occurred at the time, date on and/or investigation, in my opinion, o	and place, and death occurred at	ue to the cause(s the time, date and) and manner as si d place, and due to	tated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	1	29c. License numbe			te signed (Month,	Day, Year)
	10			HYSICIAN	D 57	543	6-	-16-06	
((1)		30. Name and address of person who of P. SANDHU M	completed cause of death (ftem 2	BAUTIMOLE S				11223
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re day	1		, , ,	. ()()

06-04296

Please Type or Print in Black Indelible Ink

Ryan Cornell Mills	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2016	1970
Physician/ Medical Examiner	Month Day Year	of Death
	4a Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Saint Agnes Hospital 4c. County of Death Baltimore City	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (S	State or
Director	Usual Residence of Decedent No. 17-04-0945 17/M 2 F 23 Yrs. Months Days Hours Min. 06-07-1983 Foreign Country)	md,
w any		de City Limits
the Maryland a or 28a-f sho tified at once Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	es 2 No
ith the N 23a or notified	334 Gwynn Ave 21229 USA 11. Marijar Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian	- Bl
or death with the Maryland or items 33a or 28a-f show any must be notified at once. Funeral Director	11. Maritaf Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian White, etc.	n, Black,
ntural", aminer	3 Widowed 4 Divorced in tes, over teal 1 Yes 2 No specify: Specify: Specify:	J.C.
5-0036 led within 72 hours lygiene. other than "natur the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+) (1 2 #6) College (1-4 or 5+)	NA
21215-0036 hould be filed within 77 and Mental Hygiene. is marked other than titre event, the Medical To Be Comple	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname)	_
2121(ould be fill d Mental F is marked tic event, To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code	9)
ME and 2 s alth as m 27	[Perri Smallwood - mother] 334 Gwyn Are Baeto, md, 212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, Sta	-
Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other ir	1 XBurial 29 Cremation 3 Removal from State crematory or other place) 4 Donayor 5 Other Specify: Cremation 3 Removal from State Abutus mem (4-27-06 Curls utus), 1	nd
Baltime permit. Pag Department Important: injury or ot	21. Signatur of Fundal Service Ling see 22. Name and Address of Facility Fire ditation Gass Cary P. march Fundal Home Balton	nd.2 Dx
Physician /Medical	23d. Fart. Enter the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approx. Between	imate Interval en Onset and
Examiner	Impute the Cause (Final disease or andition resulting in death) a. Gunshot Wounds (2) to Back and Thigh Due to (or as a consequence of):	Death
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
red usit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
execut an and al - tra		
8760, ifficate be ng physic is the bur n/Med		Year
box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
1 of Vital Records, P.O. B ling Physician: The law requires that the dearer the residual specificate has been signed by the funeral director, page 2 should be detached on: To Be Completed by Physician 10 by 10		_
rds, Frequires been sign hould be	1 Yes 2 No 3 Probably 4 24a Was an 24b. Were autopsy findi	
Records, : The law requires ficate has been sign yage 2 should be Completed	autopsy prior to completion performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2	of cause of
/ital vician: us certiff director, o Be (25. Was case referred to medical 26.Place of Death (Check only one)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burification: To Be Completed by Physician/Medi	77 Manner of Double 29a Date of Joine 29b Time of Joine at World 20d Double to 1	
Division o vithe Hospital or Attending within 24 hours after death. To the Funeral Director: Afti completely filled in by the fune ledical Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Investigation)	Number, City
Di Lospital 1 hours a 1 uneral J ly filled		City , MD
To the Hospital within 24 hours To the Funeral completely filled	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
2	29b. Signature and title of certifier O.C.M.E. 29d. Date signed (Month, Day, Yill) June 20, 2006	ear)
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar	JUN 2 2 2006 Kleven & Aprile	

			•	State of Man	yland / Depa		lealth and M	ental Hygi	iene 006	19706
				Registrar 1. Decedent's Name (First, Middle, Last)		timodito or	Dodin.	2. Date of Deatl	eg. No.	3. Time of Death
		Physicia	an	DAVID MICLEOD				Month JUME	Day Year	5: 258M
		/Medic Examin		4a, Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death	<u> </u>	4c. County of Death	1
		Examin	er	FUTURECARE-OLD COURT		RANDZ	ALLSTOWN		BALTIMO	ਸ਼ਰ
		Funeral			In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth		place (State or Foreign intry)
\		Director		250 387522 18M 20F	87 Yrs.	MONITS Days	Mours Will.	8. Date of Birth (Month, Day, 01/28/	1919 S.	CAROLINA
1	2	> 3%		Usual Residence of Decedent 10a, State 10b, County 1	Oc. City, Town or Loc	cation				10d. Inside City Limits
0	aryla	shov	2	MD BALTIMORE	-	ALLSTO	VN			1 ☐ Yes 2√☐ No
V	e M	28e-f	ect	10e. Street and Number		10f. Zip Code		1/	Og. Citizen of What Co	intry?
mclead	death with the Maryland	if of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other treumatic event, the Medical Examiner must be notified at	Funeral Director	8 CHADBURY COURT		211	33	"	USA	,
2	leath	ns 23	era	11, Marital Status 12. Was Decedent Eve	er in U.S. 13. y	Was Decedent of h	tispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - Amer	ican Indian,
4.	tter O	r iter	표	Armed Forces? 1 Yes 2 No I Yes 2 No	i			Hican, etc.)	Black, White	
W	030 surs	- E	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1□Yes 2√7%	Specify:		Specify: BL	ACK
6	5-0 72 hc	natu	etec	15. Decedent's Education (Specify only highest grade completed)	(Give	tent's Usual Occup kind of work done	during most of working	ng	16b. Kind of Business/I SUMTER T	ndustry
\$	121 within	han.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retire			COMMUNIT	COLLEGE
B	2 2	tygie her t		9TH 17. Father's Name (First, Middle, Last)	JANIT	ORIAL S	18. Mother's Name	(First Middle A	Asiden Sumame)	
1	and	od of	8	CHARLIE McLEOD				JOHNSO	-585	
	Maryland 21215-003	n and Mental Hygiene. 7 is marked other than ". reumatic event, It a Med	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			City or Town, State, Z	ip Code)
	Ma d2s	th an		LATTUSE A. McFADDEN/NEPI	1				TOWN, MD	
	ē	Hea tem other			20b. Place of Dispos				20c. Location - City or	
	no	ont of t: If i		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	WALKER			1/06	SUMTER,	SC
	Baltimore,	Department of Health a Important: If item 27 is any injury or other tre 2002.		21. Signatur- Puneral Service Licensee	22	. Name and Addre	ess of Facility HC	_	UNERAL HO	
	m a	9 5 9		1 /Why 188. 800	M 4	600 LIE			VE, BALT	
				23a. rint Inter the disease, or complications that caused the social or hear failure. List only one cause on each line.	e dath. Do not ente	er the mode of dyi	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
	PT	nysician		Imm is e Cause (Final		MENT			J	Onset and Death
	4 /	Medical		disease or condition residing in death) a. Due to (or as a condition of the condition of t		1418:41				
		xaminer		Sequentially list conditions b.						
	0	=	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discost of more) that initiated events c.	onsequence of):					
	ecute	and -trans	Cam	that initiated events resulting in death) Last C. Due to (or as a c	consequence of):					
	760, te be executed	attending physician and for use as the burial-transit	cal E)	500 to (c) 43 4 5	chisequance or).					
	> 9	physi the		d						
	X 6	iding se as	Physician/Medi	IF FEMALE: 23c. If yes, outcome of	pregnancy				23d. Date of deli	/erv
	Bo	atter for u	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		Ectopic pregnanc Other (specify) _	у		Month	Day Year
	o §	y the ached	hys	9 Unknown						
	Vital Records, P.O. Box 68 sicien: The law requires that the death certifical	been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
	rds	an sig						1 □ Ye	s 2 No 3 Pro	bably 4 Onknown
	S × S	as be	plet					24a. Was at		opsy findings available ompletion of cause of
	A P	certificate has rector, page 2	Completed					perform 1 ☐ Yes 2	ned? death?	2 No
	ita	ertifica ctor,	Be	25. Was case referred to medical examiner?			26. Place of Death			
(of V	his ca	ို	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien				nce 6 Other (Spec	ify)
XiV] C 2	Viter 1	on:	27. Manner of Death 1 ☑ Natural 5 □ Pending 28a. Date of Injury (Month, Day Y	/ear) 28b. Time of Injury	Wo		28d. Describe ho	w injury occurred	
(')	Sio	for: /	icat	2 Accident investigation 3 Suicide 6 Could not be 38e Place of Injury	. At home form etc		Yes 2□No	28f Location (St	reet and Number or Ru	ral Pouta Number
\sim	Division or Attending	Direct Direct in by	Certification:	4 Homicide determined building, etc.	r - At home, farm, str (Specify)	eet, lactory, office		City or Town		ar rioute realizer,
	A letter	ours cours and a series		29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death	n occurred at the ti	me, date and place, a	and due to the ca	use(s) and manner as	stated.
	H _o	24 h e Fur	Medical	(Check only 2 Medical Examiner: On the basis of example) and manner state	xamination and/or inv	vestigation, in my	opinion, death occurre	ed at the time, da	ate and place, and due	to the cause(s)
	Toth	within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, to	Me	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Month	
		1		162 K.S. NAO. F	-0	01	13462	0	14E 1d	2006
_	ኅ ່	0		30. Name and address of person who completed cause of dea	th (Item 23a) (Type,	Print) 14. 5.	RAC. M.	0.		
				Syon OLD Court noA	2 # 10	8 000	TOALLS	Tewar	10 Z	1127
		Sta Regist		31. Date filed (Month, Day, Year) 32. Redistrar	S S A	barte				

06-04201 Jennifer Mcaulay

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death 2006 19707

		1- For State Registrar	•	Certific	ate of	Death			Reg. No.	200	6 19/0		
Physicia	in/	1. Decedent's Name (First, Middle,						2. Date of De Month	eath Day	Year	3. Time of Death		
ledical Exami			er McAulay					June 17	2006		1507 hrs		
		4a. Facility Name (if not institution, Shady Grove Adventist	,		46	. City, Town, or L Rockville	Location of De	ath		ounty of Death	'		
Funeral				(In yrs, last birt	hday)	If Under 1 Year	If Under 24	Hrs. 8. Date of I			thplace (State or		
Director			M 2 XF	54	Yrs.	Months Days	+		7, 195	Foreig			
	- 1	Usual Residence of Decedent	IVI Z ZNF		115.	L		DEG	, 100	1 000	-1.57/Calliolilla		
any	ŀ	10a. State 10b. County		10c. City, Town	or Locatio	n					10d. Inside City Limits		
nd Show	١	Maryland Montgo	omery			Gaithe	ersburg				1 Yes 2 No		
Maryland 28a-f show any <u>d at once.</u>	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cour	ntry?		
the M a or 2 tiffed	ᆲ	30 O'Neill Dri	ve. Apt. #1			208	377			USA			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho maric event, the Medical Examiner must be notified at once.	ara l	11. Mantal Status	12. Was Decedent B	Ever in U.S.		Decedent of Hisp			No- 14		can Indian, Black,		
death or ite	Funera	1 Never Married 2 X Mar	1 Yes 2	X No	li re:	s, specify Cuban,	, Mexican, Pue	eno Rican, etc.)		White, etc.			
after	à		ced If Yes, Give Year or Dates:			res 2 X No					ite		
hours 'natu Exan		15. Decedent's Education (Specific Elementary/Secondary (0-12)	y only highest grade com College (1-4 or 5			s Usual Occupations of working life.				d of Business/I	·		
36 hin 72 han '	ompleted	Elementally/Secondary (0-12)	1		Para	Educator	^			legomer lool Sys	y County		
d with	Con	17. Father's Name (First, Middle, L	ast)		ara			ame (First, Middle			s ceni		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be (Frederick St	inson Baker			1	Wi	lda Pon	tius				
21 ould I d Mer ic eve		19a. Informant's Name/Relationshi	p (Type, Print)	19							, Zip Code 20877		
MD d 2 sho lth and n 27 is aumatic	- 1	George F. McAul	ay II/Husbar			'Neill I							
re, slan fHea Fiter		20a. Method of Disposition 1 Burial 2 A Cremation	3 Removal from Sta		of Dispositi tory or othe	ion (Name of cem er place)	netery,	Date	20c. Loc	cation - City or	Town, State		
Page nent o		4 Donation 5 Other Spe			Crem	atory, I	Inc. 6	/21/06	Bal	timore	, MD		
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo during most of working life. Do NOT use retired to the property of the prop								remation	emation Society of MD, Inc.				
	-1	Morand 4.	fr.nll		29	<u>9 Freder</u>	cick Ro	ad Balt:	imore.	MD 212	228		
Physician /Medical	Į,	23a. Part I. Enter the disease, or c failure. List only one causes	n each line.					ic or respiratory a	arrest, snock	, or neart	Approximate Interval Between Onset and		
"xaminer	- 1	Immediate Cause (Final disease or condition resulting in death)	a. Loxapine and Due to (or as a conse		pam in	toxication	n				Death		
		Sequentially list conditions,	b.	quonico 01).									
	ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):									
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):									
ficate be executed gphysician and the burial - transit	- 1		d										
) oe exe ician a	Physician/Medical	X UNPENDED	_ AMENDED ite	n#23a,27,	28a-f,	perME,g857	7,7/10/0	5 TT					
760, ficate be g physicii the buria	Se l	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnancy					23d. E	Date of delivery			
Sox 68 leath certifi e attending for use as	lä	past 12 months?	1 Live birth Pregnant at t	the said the said			Ectopic pre	gnancy	Me	onth [Day Year		
Box 68 to death certif the attending ted for use as	ıysi	1 Yes 2 No 9 V Unkn			J Ottne	er (Specify)							
ires that the de signed by the		Part II. Other significant condition	ns contributing to death	but not resultin	g in the un	derlying cause gi	iven in Part I.	23e. Dio	tobacco use	e contribute to	the cause of death?		
ires th	Completed by							_ 1 _ 1	es 2 N	lo 3 Prob	oably 4 🗸 Unknown		
cords law requi has been	lete							24a. Wa	is an opsy		topsy findings available completion of cause of		
eco he law ite has	Ę							per	formed?	death? 1 ✔ Ye			
tal Rec cian: The l certificate l ector, page		25. Was case referred to medical				26.Place	of Death (Che		, =		2 110		
Vita hysicis this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗸 ER/O	utpatient	3 DOA	Other Nu	rsing Home 5	Residence	e 6 Other	:		
ion of tending Pheath.	圁	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	y 28b.	Time of Inj	·	y at Work?	28d. Describ	e how injury	occurred			
ion Itendi Feath. Tor:	덇	Natural 5 Pendir 2 Accident Investi		2006 12:	30 pm	1Y	es 2 No	subject	ingest	ed drugs			
Division of Vital Records, P.O tal or Attending Physician: The law requires that t rs after death. al Director: After this certificate has been signed by lef in by the funeral director, page 2 should be detac	Certification:	3 X Suicide 6 Could	not be 28e. Place of Inj		arm, street	, factory, office bu	uilding, etc.	28f. Location or Town	(Street and State) 30	Number or Ru	ral Route Number, City		
Spital nours filled	Š	4 Homicide determ	ined (Specify) res	sidence				Gaithers	burg, M	DORCHIL	Dr. Apt #1		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ical	(Chook only	sician: To the best of my iner: On the basis of exan	-									
To t	Medical	29b. Signature and title of certifier	and manner stated.			29c. License				te signed (Moi			
	=		n,			O.C.N				18, 2006	, Day, 10a/		
		30. Name and address of person w		ath /Item 23cl									
5 ok perd			t Medical Examiner		n Street	, Baltimore, N	MD 21201						
	ate	31. Date filed (Month, Day, Year)	32 Registrar		de	V. 2							
Regis		JUN 2 2 2	1006 Shalin	15.	61004								

State of Maryland / Department of Health and Mental Hygiene 🕦 🎧 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2006 Year 18, Martin-Poist June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 719 Maiden Choice Lane, HV321 Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year, 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F Director 226-24-1437 83 June 12, 1923 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event. It a Medical Examinar must be nutified at Maryland Baltimore Catonsville Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6 719 Maiden Choice Lane, HV321 "natural', or Itama 23a 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itan any Injury or other traumatic event, Ita Medical Exercited 2068. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Records Clerk U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Hall Mabel Virginia Patton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1555 Hwy 95 East, Clinton, AR 72031 John A. Martin / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) Meadowridge Mem. Park 6/22/06 Elkridge, Maryland 2 Sun Jure of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funerall Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyperlipidemia 1 Yes 2 No 3 Probably 4 donknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Division of Vital 1 ☐ Yes 214 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1/6 Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) mpletely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 044377 Dennen Bowling 1410 Mouden Choice bare, Catenoville, MD 21028 31. Date filed (Month, Day, Year) 32. Signature State Joseph Registrar JUN 2 2 2006

			Please T		Black Indelible In		-	_	
			For State Registrar	State of Maryla	nd / Department of		lental Hygier	ne anne	9719
					Certificate of	Death	Reg. I		
	Physici /Medi		1. Decedent's Name (First, Middle, Last)	tie L.	mak	el	2. Date of Death Month	Day 2006 3.	Time of Death
	Examir	ner	4a. Fecility Name (If not institution, give	treet and number)	eal 4b. City Jown,	or Location of Death	rare	4c. County of Death)
	Funeral Director		5. Social Security Number 6. Sex	M 2 7. Age (In yrs	(s. last birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea	ar) 9. Birthplace Country)	(State or Foreign
	D.		Usual Residence of Decedent 10a State 10b. County	1000	Dity, Town or Location		Ague 4,	1977/10UW	Carriena nside City Limits
	e Maryla Se-f eho	Director	and 1	VA	Jal Dal	tem	ne		es 2 No
	th with th	al Dire	10e. Street and Number	Mcca	Re Ave 2	21212	10g.	Citizen of What Country?	pre-
	ems :	Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	U.S. 13. Was Decedent of	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American In- Black, White, etc.	dian,
21215-0036	be filed within 72 hours after death with the Maryland stal Hygliene. ed other than *naturel*, or items 23a or 28e-f ehow event, the Medical Exartinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □ Yes 2 □ XN		,	Specify: 36	eck
15-0	in 72 h n *natu fedical	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	during most of worki	ng 16b.	Kind of Business/Industry	
	filed within Hygiene.		Elementary/Secondary (0-12)	College (1-4or 5+)	Flor	ist	£	Decerative	Flower
Maryland	should be fill the Mental Himarked ott	o Be	17. Father's Name (First, Middle, Last) Willie	Feather	stone	Tanne	o (First, Middle, Maid L Bell	(en Sumame)	ings)
Mary	and is m	-	19a. Informant's Name/Relationship (Ty)		19b. Mailing Address (Stree	at and Number or Rura	l Route Number, Cit	y or Town, State, Zip Code	a)
	s 1 and f Health Item 27 other tr		Damon Will 20a. Method of Disposition	20b.	Place of Disposition (Name of cemetery, crematory or other place)	510 41,	pate 20c.	Location - City or Town, S	2/2 State
Baltimore,	nit. Peges artment of i ortant: if its injury or o		1 ⊠Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	A X	Farrison 4.	viest 6-2	3-06 OU	vings ne	lls, md.
Ball	permit. Peg Department Important: I eny injury o		21. Signifure of Funeral Service Lice Servic	1,00,00	22. Name and Addr	ess of Facility 405 will m. wall	Rankle Frence	ial Service	Balto.
			23a. Part LEnter the disease, or complication shock, or heart after. List only on	cations that caused the dea e cause on each line.				Appr	roximate rval Between set and Death
	Physician /Medical		Immediate Cause (Find disease or condition resulting in death)	Due to (or as a consec	small ce	II June	y Can	eer on	le year
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	rtificate ng phys as the	Medic	d						
Вох	leath certificate ettending phys I for use as the	Physician/Medic	in the past 12 months?	Bc. If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of c	al death 3 □Ectopic pregnand	су		23d. Date of delivery Month Day	Year
P.O.	at the de by the stached	hysic	1 □ Yes 2 N/No 9 □ Unknown	9□ Unknown					
rds, l	w requires that been signed b should be det	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to the cau 2 □ No 3 □ Probably	
of Vital Records,	e law re has bee je 2 sho	Completed					24a. Was an autopsy	24b. Were autopsy fir prior to completion	ndings available on of cause of
la	sician: The l certificate ha rector, page	0	25. Was case referred to medical			26. Place of Death	performed?		40
of V	Physici this ce al direc	ToB			JENOutpatient 3 DOA	her: 4 Nursing Hor	ne 5 Residence	6 □Other (Specify)	
on	nding F ith. :: After e funera	ation:	27. Manne of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury 28c. Inju Wo	ıryat 2 ork?]Yes 2 □No	8d. Describe how in	jury occurred	
Division	il or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, office	2	8f. Location (Street and City or Town, Sta	and Number or Rural Rout	te Number,
1	To the Hospital or Attending Physician: The law requires that the death certificate within 124 hours after death. To the Funeral Director: After this certificate has been signed by the eitending phy, or mpletely filled in by the funeral director, page 2 should be detached for use as the	edicai Ce	(Check only Z Medical Examin	er: On the basis of examina	owledge, death occurred at the tation and/or investigation, in my	ime, date and place, a	and due to the cause	(s) and manner as stated.	rause/s)
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.		se number		Date signed (Month, Day,)	
	- s - ŏ		14 Lonance	Span	mD AT	243894		une 17, 8	2006
	3		V	Thana	m 23a) (Type, Print)			Memoria	1 Har
	Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1110)	VIII 0/1	110110110	-1 Mospi
	Registr	ar	JUN 2 2 200	6	L 1-4				

State of Maryland / Department of Health and Mental Hygiene ?

			1 - State Registrar			Cer	tificat	e of l	Death	1		Reg. h	No.			
	Dhysici	20	1. Decedent's Name (First, Middle, La								2. Date of De Month		Day	Year	3. Time of Death	
	Physici /Medio		<i>J</i>	rris								JNE	20	, 2006	8:25P M	
	Examir	er	4a. Fecility Name (If not institution, given Saint Joseph		Cente	P7	4b. City,	Town, or	Location	of Death	on	4	4c. Count	ty of Death Balt	imore	
ī	Funeral		Social Security Number 6.3	Sex 7. Age	(In yrs. last bir		If Under Months	1 Year Days	If Under Hours		8. Date of Bi (Month, Di Jan. 3	rth ay, Yea	(ar)	9. Birthp	lace (State or Foreign	
	Director		Usuel Residence of Decedent	- X	13	113.			L		Jan. 3	, 1	931	renn	ýlvania	
Vland	Mo W		10a. State 10b. County		10c. City, Tow	n or Loc	cation							1	0d. Inside City Limits	
∑	- 9	ctor	Maryland Harf	ord				Str	eet						1 ☐ Yes 2 💢 No	
đ.	or 26	Dire	10e. Street and Number				10f. Zip	Code	0111	- 1		-		What Coun	try?	
eath v	23	eral	3461 Mill Gree	12. Was Decedent E	ver in II S	12 14	Vac Dagge	tent of U	2113		ecify Yes or N		U.S.	A . ice - Americ	an Indian	
U. Z. I.Z. 13-0050 filed within 72 hours after death with the Maryland	f Health and Mental Hygiene. Item 27 Ie marked other then "naturel", or Iteme 23s or 28s-f ehow other traumatic event, the Modical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If	Yes, spec	offy Cuba	Specify:	n, Puerto	Rican, etc.)	0-		ack, White.		
2 K	na fa	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Deced (Give I	ent's Usua kind of wor OO NOT us	al Occupa	ation during mos	st of worki	ing	16b.	Kind of E	Business/Ind	dustry	
	hen.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+	-)		o notus Teta)			Ra	Ptim	ore Co	untu	
iled N	Hygie nt, th		12 17. Father's Name (First, Middle, Last	·)		Sec	neru	rig	18. Moth	er's Name	(First, Middle				uncy	
6 8	ked o	To Be	Nicholas Phi	llips							dine		rove			
Shou	and Mental Hygiene. le marked other then " aumatic event, the Mac	-	19a. Informant's Name/Relationship								A Route Numb				Code)	
and 2	lealth and 27 lear tra		Mrs. Cathy Weir	(daughte	r) :	3461	Mil	l Gr	een F	Road,	Stree	t, 1	MD 2	1154		
U	of He of He or oth		20a. Method of Disposition 1 🔀 Burial 2 🔲 Cremation 3	Removal from State	20b. Ptace of cemeter	v. crem	atory or o	ther plac	e)		200	0		- City or To		
Pages	tant:		4 □ Donation 5 □ Other (Speci	(y)	Garde										laryland	
Dail	Department of H Important: If Ite any Injury or of once.		21. Signature of Funeral Service Lice	ulle.			Name an				himune altimo				nes	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CARDIOGENIC SHOCK													
	nysician		Immediate Cause (Final disease or condition resulting in death)	a. CARDIO	OGENIC	SH	IOCK							9	Onset and Death	
	Medical xaminer		Toodang in doubly	Due to (or as a	consequence		OPCI	r t mk	3							
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a			HIVE:							-		
pented	ransit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events	. CORONA	ary Ar	TER	Y DI	SEF	SE							
5 e e e e	ien ar urial-t		resulting in death) Last	Due to (or as a	consequence	of):										
certificate be executed	physic s the b	Medical	•	d. KESPII	RATORY)" h-	ITLU	TE.								
Sertifi	nding use as	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy								23d. Da	ate of delive	rv	
he death	been signed by the ettending physicien and should be detached for use as the buriat-transit	Physician	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1□Live birth 2 4□Pregnant at ti 9□Unknown	Petal death		Ectopic pro Other (sp								Day Year	
that t	ed by		Part II. Other significant conditions	contributing to death but	t not resulting in	the un	dertying ca	ause give	en in Part I	ı.	23e. Did 1	obacco	use con	tribute to th	e cause of death?	
	an sign	ed by									10	Yes	2/2 No	3 🗌 Proba	ably 4 Unknown	
a we	s bee 2 sho	Completed									24a. Was		24b.	Were autop	sy findings available	
The	ete he pege	E									auto perfo	rmed? 2XIN		death?	pletion of cause of	
cian:	ertific actor,	Be	25. Was case referred to medical examiner?							of Death	(Check only	/			A	
Physic C	this c al dire	P	1 ☐ Yes 2 No	Hospital: 1 Inpatien		·			4 🗆 INI		ne 5□Resi)	
ending	within 24 hours after death. To the Funarel Director: After this certificete hes been signed by the etter completely filled in by the funeral director, pege 2 should be detached for u	catlon	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be			ime of niury	м 2	8c. Injury Work 1 🔲 \	rat (? /es 2 □	1	28d. Describe	how int	tury occu	rred		
lel or Att	s after d	Certification	3 Suicide 6 Could not b 4 Homicide determined	28e. Ptace of Injur building, etc.	y - At home, fa (Specify)	rm, stre	et, factory	, office		2	28f. Location (City or To	Street a wn, Sta	and Num. ite)	ber or Rural	Route Number,	
e Hospi	within 24 hours after deatl To the Funarel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example (Check only one)	nysicien: To the best of miner: On the basis of and manner state	examination and	, death d/or inve	occurred a estigation,	at the tim	e, date ar pinion, dea	nd place, a oth occurre	and due to the ed at the time.	cause((s) and m nd place,	anner as sta and due to	ated. the cause(s)	
To th	withir To th comp	ž	29b. Signature and title of certifier	1 1		W	290	License	number			29d. D	ate signe	ed (Month, E	Day, Year)	
	T		Kichard	LLIM	tricus		_	D31	826			6	,-Z	1-0	6	
8	, ,		30. Name and address of person who													
	Sta		RICHARD LIN 31. Date filed (Month, Day, Year)	32. Registrar		21	OSLE	ER I	RIVE	<u> </u>	WSON,	MA	RYL	AND E	1204	

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

JUN 2 2 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 20 T.IDA M UME 2006 MacDonald /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie If Under 1 Year If Under 24 Hrs. Battimore - Washington Medical Center
5 Social Security Number 6 Sex 7 Age University State Dir Anne Arundel Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-50-4418 57 Director Sept.20,1948 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland <u> Anne Arundel</u> Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 212 10th Street 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □XYes 2 □ No If Yes, Give Year or Dates: 71 - 77 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 other then "natural", or 1 ☐ Yes 2 🕱 No ۵ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Chemical Company 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if tiem 27 is marked oth any injury or other traumatic event 20ce. 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Thelma Percival MacDonald Schollsburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret C. MacDonald-Wife 21210th Street, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery June 23,2006 Brooklyn, Maryland 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service-Licens usche <u>3111 Mountain Rd., Pasadena, MD 21122</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each (i.e. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GREBRONASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Wunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No : After this certifical funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manney of Death 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) UNE 2006 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eu burnie Hospital 32, Registrar's Signature. 31. Date filed (Month, Qay Year) State Registrar

Mac Donald,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** 52 artin June McCra 19 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Catons VIIIc Baltimore Forest Nursing Home 7. Age (Inyrs. last birthday) Haven 6. Sex 100M 2□F 8. Date of Birth Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 86 Yrs. Days Min 218-10-8555 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28e-1 show or other treumatic event, the Mcdical Examinar must be rediffied at Baltimore MD 1 Yes 2 No atowsul Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 932 Prest States 21228 United Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 7No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

CARC TAKER 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other treumatic event, the Meany Injury or other treumatic event, the Meany Dings. College (1-4or 5+) Elementary/Secondary (0-12) NAT, CEM, TAKER 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bridsall ပ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice Cray - Son 932 Kd. Latonsville and 21228 Frestwood P 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place 1 2 Burial 2 Cremation 3 Removal from State VA June 26, 2006 Owings Mills MD Farrison * 4 ☐ Donation 5 ☐ Other (Specify) Property of 11651 Bay FUNCRAL SERVICE 21. Signature of Funeral Service Licensee 11651 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ZHEIMER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2,☐ No 23d. Date of delivery 3 Ectopic pregnancy should be detached for Dav 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1 Yes 2/2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 1 Yes 2. No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Director; After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number sulle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SNEEN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 2 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖺 🧎 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 325 A M GRACE ELIZABETH NEWLON June 21 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗗 F 220-14-7306 Yrs. Director 9/1/1912 WEST VIRGINIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be nutified at 1 ☐ Yes 2X No Director HARFORD EDGEWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 1922 CHIPPER DRIVE USA or Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 2 should be filed within 72 hours and Mental Hygiene. Is marked other then "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE PAYROLL CLERK FOOD INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HENRY GASSAWAY ESTELLA SEIGH 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Itsm 27 is n any injury or other traun once. DAVID GRAHAM/GRANDSON 442 KENTMORE TERRACE ABINGDON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State LORRAINE PARK CEM. 6/23/2006 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses TOWSON, MD 8521 LOCH RAVEN BLVD. 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): 3 years disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown been sign Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 🗌 Yes 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗙 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Accident s after dea... ral Director: Aftr 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a 29a. Certifier Jecentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and 29d. Date signed (Month, Day, Year)

Registrar

Vew lon

31. Date filed (Month, Day, Year) 2 2006

DR Anastasios Saliaris 9000 Franklin Square Drive Baltimore Maryland 21237 32. Registrar's Signature

Silean and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

6-21-2006

			1 - State Registrer	State of Mary		artment of F rtificate of			giene 20	06 19714		
	Physici /Medi											
1	and 2 should be filed within 72 hours after death with the Maryland at hard Mental Hygiene. 27 is marked other then "natural", or iteme 23a or 28a-f ehow an artreumatic event, the Madical Examiner matched an or treumatic event, the Madical Examiner must be notified at the madical examiner matched and a part of the madical examiner matched and a part of the madical examiner matched and the madical examiner matched and the madical examiner matched and the madical examiner matched and the madical examiner matched and the madical examiner matched and the madical examiner matched and the madical examiner matched and the madical examiner matched and the matched and t	ner		IRE HOSPIT		ROSED		8. Date of Bir	BALT IN	norc		
			5. Social Security Number 6. Se 217-34-6968 1D	7	F 68 Yrs.		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		th Year) 29,1937	9. Birthplace (State or Foreign Country) Maryland		
		ctor	10a. State 10b. County Maryland Baltimo		: City, Town or Lo	ocation Middle	River			10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
		rai Director							u.s	g. Citizen of What Country? U.S.A.		
land 21215-0036		by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ★ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify: 			- 14. Race Black Specify:	Race - American Indian, Black, White, etc. Ocity: White		
		Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)				ing	16b. Kind of Bus	iness/Industry		
		To Be Co	12 17. Father's Name (First, Middle, Last) John Baptist Co	ellitto	S	ecretary	18. Mother's Name			ce Defense		
, Maryland		-	19a. Informant's Name/Relationship (Ty Robin Ann Huddler	, ,			and Number or Run	al Route Numbe				
Baltimore,	r. Pages 1 rment of He rtant: if Iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Asinoval from State	Most Hol	isition (Name of natory or other plac y Redeeme	r 6/21/	2006		city or Town, State		
Bal	Departr Departr Import any in		21. Signature of Funeral Service Licens		9		ir Rd., B	altimor		2 Homes 236		
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien and posicion and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or but and a posicion and a po		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Interval Between Conset and Death disease or condition resulting in death) Due to (or as a consequence of):									
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Congulopathy Due to totals a consequence of): c. DVT Due to (or as a consequence of): d. Hypertensor						1 mounth		
		edicai Examin	that initiated events resulting in death) Last							IYEAR		
P.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							of delivery h Day Year		
		Part II. Other significant continuous contributing to death but not resulting in the underlying cause given in Part I.								e contribute to the cause of death? No 3 Probably 4 Unknown		
al Reco		Completed						24a. Was a autop perfor 1 ☐ Yes	sy prie	ere autopsy findings available or to completion of cause of ath? ☑ Yes 2☐ No		
n of Vit		n; To Be	25. Was case referred to medical examiner? 1									
Division of Vital Records,		Certification;	Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	Yes 2 □No	2 □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		edical Co	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
)		Me	29b. Signature and title of certifier					9d. Date signed (Month, Dey, Year)				
7	Ò		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	Print) Klin Squ	JARE DRI	VE Ba	Llimore	MD 21237		
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 2 20	05 States	Ignature IF	mele			,			

			1 - For State Registrer	State of	Marylar	nd / Depa <i>Cer</i> i	rtment of tificate o				jiene	006	19	715	
	9-		1. Decedent's Name (First, Middle, Last)					2. Date of De				Death 3. Time of Death			
	Physici /Medio		Kenneth Mitchell Otto							Month TUNE &	Day	Yeer	205	AM	
	Examin		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City, Town	, or Location				inty of Death			
			BALTIMORE WASH	NOTON F	LEDICA	L Cente	610	S BUR	UIE		AL	1 Cour	UTY		
	Funeral			Sex 7.	Age (In yrs.	. last birthday)	If Under 1 Ye		24 Hrs. (B. Date of Birth (Month, Day	Year)	9. Birth	place (State ontry)	or Foreign	
	Director		213-16-5975	1 ⊠ M 2□F	85	Yrs.		110010		05/14/1	921	Mary	land		
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Loc	eation						10d. Inside C	ity Limite	
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Itama 23e or 28e-f ehow amportant: if Item 27 is marked other than "netural", or Itama 23e or 28e-f ehow any Injury or other traumatic event, the Medical Examiner must be notified at once.	Director											2 No		
	28a-		106. Street and Number 10f. Zip Code 10g. Citizen of What Cour												
	with se or	<u></u>	25 South Calhoun Street 21223								ed Sta	•			
	ne 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in L	J.S. 13. W	/as Decedent of		igin? (Spec	ifv Yes or No-		Race - Ameri			
(0	ritar	Ξ	1 ☑ Never Married 2 ☐ Married	Amed Force		lf lf	Yes, specify C	uban, Mexicar	n, Puerto R	ican, etc.)	E	Black, White,	etc.		
ဇ္ဇ	ed', o	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:	1	☐Yes 21XIN	lo Specify:			Spe	city: Whi	.te		
21215-0036	72 hc	Completed	15. Decedent's (Specify only highest g			16a. Decede	ent's Usual Occ	cupation	t of working		16b. Kind o	f Business/Ir	dustry		
7	ithin		Elementary/Secondary (0-12)	College (1-4	or 5+)	life. D	O NOT use ret	ired)	e or working						
	ygier ygier har th		12	N/A		Lice	ense Cl					Gover	nment		
and and	be fi	To Be	17. Father's Name (First, Middle, Las	17)						First, Middle, I		name)			
Maryland	d Mer nark		George Otto	(Time Deine)		401-14-15-1	4.11	_1		ola Fog					
ā Z	d 2 sl th an 7 is r traur		19a. Informant's Name/Relationship	547			Address (Stre								
	1 en Heel em 2		Joyce A. Johnso 20a. Method of Disposition	ii (Execut	20b.	Place of Dispos	Wendell ition (Name of		e, Da Da		•	y Lanu on - City or T			
2	ages intof t: If In		1 ☑ Burial 2 ☐ Cremation 3		310	cemetery, crem orraine			06/26			-	Maryla	. Dar	
Baltimore,	artme ortan		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		IX								_	ina	
Ba	Depa Impo Impo any i) Like	Lind			Name and Add	kens A	venue	, Baiti	more,	Home, Maryl	Inc. and 21	1229	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											tween	
			Immediate Cause (Final disease or condition	a CER	EBR	OVASC	ULAR	AC	erD	ENT			2 Hou		
	/Medical Examiner		resulting in death)		as a consec	quence of):									
		e	Sequentially list conditions,	b. ATRI	AL		JLLA	TON	,						
		nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
	xecur and	Examin	that initiated events resulting in death) Last	c	as a consec	quence of):									
8760	ficate be executed physicien and the burial-transit	dicai E													
687	ificate g phy as the	edic		d											
ŏ	anding use	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. I	Date of deliv	эгу		
m	death e atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth	t at time of o		Ectopic pregnar Other <i>(specify)</i>					Month	Day *	Year	
P.O. Box	tt the by th tache	hys	9 □ Unknown	9□ Unknow	n 										
s,	uires that the death certifications signed by the attending does not be detached for use as	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of c				leath?	
Ž	w require been si should I									1 □ Ye	s 2 No	3 ☐ Prot	oably 411	Unknown	
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/ita	cian: ertific actor,	Be (25. Was case referred to medical examiner?					26. Place	Death (Check only on	е)				
<u>}</u>	hysi this c	ဥ	1 Yes 2 No							5 ☐ Residence 6 ☐ Other (Specify)					
Ĕ	ing P	Certification;	27. Manper of Death L□ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim			of 28c. Injury at Work?			d. Describe ho	curred				
S	ttend death ttor: , the f		2 Accident investigation 3 Suicide 6 Could not	ho -						(2)					
<u>≥</u>	at or Attan a after deatl Director: d in by the	ertif	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attan within 24 hours after deal To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 29a Certifier (Check only one											6)	
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. C															
								TUNE ZO, 2006 NGTON AUDINE MD 212.26							
	(X)		30. Name and address of person who	completed cause of	of death (Iter	m 23a) (Type P	rint) / =	710	CALA	1.01/:	VNE	_ ~)		
	18,			LACON		. / (- /	BAR	TIMO	RA	MI) 7	177	INVE	-	
702	Sta		31. Date filed (Month, Day, Year)		strar's Signa	ature	0-	,,,,,,		, _		1			
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DHMH 17 Rev 1/2001

OTTO KENNETH

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 2006 ar Physician Month 17 ay Person 9:20a Janet /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Villa N.H. Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 ☐ M 2 🛱 F Yrs Director 242-24-0186 85 8-18-20 N.C. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at 1 X Yes 2 □ No Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 2553 W. Lafayette Ave. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or ttame 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black þ Specify 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry le marked other then Elementary/Secondary (0-12) College (1-4or 5+) NA Disabled 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental int: If tem 27 le marked o Unkn Person Rosetta Johnnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2553 W. Lafayette Ave., Baltimore, Md. Sandra Corporal Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If eny Injury or once. 6-26-06 Laurel, Md. Md. Nat. Mem. Pk. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Satuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Dunknown 1 □ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death (Check only one Hospital: Other: 1 ☐ Yes 2 ☑ No 2 1 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred After t 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 ☐ Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge death annurad at the time. 34th and clark and due to the cause(s) and marrier as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number completed cause of death (ftem 23a) (Type, Print) HANI 1220 egistrar's Signature 31. Date filed (Month, Day, Year) 32. State Registrar

			1 - For State Registrar	State of Maryland		artment of rtificate o		Reg	ene 0 0 6	19717
	Physici /Medi	al	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give	Purpel1	/	4h Cihi Toum	or Logation of Do	2. Date of Death Month	Day Year	3. Time of Death 7= 53 M
	Examir Funeral Director	ier	5. Social Security Number 6. Security Number 1218–40–1818	Hapital	ast birthday) 8 Yrs.	If Under 1 Yes		rs. 8. Date of Birth (Month, Day,)	4c. County of Death Stranger 9. Birth Con 1907 Ne	-
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or items 23s or 28s-f show any Injury or other traumatic event, Ira Modical Examinar must be notified at ODGS.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo: 10e. Street and Number 6825 Campfield 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) John Edward McG (19a. Informant's Name/Relationship (Ty. Harold Purnell/Soil 20a. Method of Disposition 1 XBurial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Road, Apt. 9A 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mol If yes, Give Year or Dates: cation completed) College (1-4or 5+) 3 OVERN pp. Print) n	16a. Dece (Give life. Ph. 19b. Mailin 209 ace of Dispo metery, created d Rid	Ball 10f. Zip Code Was Decedent of Yes, specify Ci I Yes 2 Xi Ident's Usual Occ kind of work dor DO NOT use reti	21207 If Hispanic Origin? Juban, Mexican, Pue Specify: Supation The during most of wered 18. Mother's N Ka Set and Number or N Talla Jace) Lery 6/	(Specify Yes or No- arto Rican, etc.) Torking ame (First, Middle, Ma therine Fe Bural Route Number, (hassee, FL Date 20	Pharmacy iden Sumane) aly City or Town, State, Zi	A nican Indian, a, etc. White ndustry Tip Code)
x 68760,	death certificate be executed by a definition of a stending physicien and a stending physicien and a for use as the burial-transit	/Medical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of pregnar	ence of):	,				Approximate Interval Between Onset and Death
Records, P.O. Box	To the Hospital or Attending Physicien: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the atten completely filled in by the funeral director, page 2 should be detached for upon page 2.	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	déath 3☐ ath 5☐	Ectopic pregnar] Other (specify) nderlying cause g	<u> </u>	1 🗌 Yes 24a. Was an autopsy performe	24b. Were auto prior to co d? death?	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
Division of Vital	or Attending Physicien: iffer death. Director: After this certifica in by the funeral director, p	Certification; To Be C	25. Was case referred to medical examiner? 1	lospital: 1 Inpatient 2 E 28a. Pate of Injury (Month, Day Yeer) 28e. Place of Injury - At hor building, etc. (Specify,	28b. Time of Injury	28c. in W	other: 4 Nursing ury at ork? Yes 2 No	eath Check only one Home 5 Residence 28d. Describe how	ee 6 Other (Speci	ify)
)	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical Ce	29a. Certifier (Check with one) 29b. Signature and title of certifier	sician: To the best of my knowner. On the basis of examination and manner stated.	vledge, death on and/or inv	/estigation, in my	nse number	curred at the time, date	and place, and due t Date signed (Month,	to the cause(s) Day, Year)
	Sta Registr		30. Name and address of person who co 31. Date filed (Wonth, Day, Year)	mpleted cause of death (Item 32. Registrar's Signate	-11	Print)	1 trans	J. Hotom	hory le	and .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma		pariment of F e <i>rtificate of</i>		•	giene Reg. No.	006	19718
ı	Physici /Medi		Decedent's Name (First, Middle, Last) ELIZABETH MAR		7			2. Date of Dea Month JUNE		Year 0.6	3. Time of Death 6:30A
	Examir		4a. Facility Name (If not institution, give s 6022 RIVERMEA		VD		or Location of Death		4c. Count	y of Death	0.30A
	Funeral Director		2 03 3010	7. Age	(In yrs. last birthda 91 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 12/04	/ 1914	9. Birthp Coun MAR	nlace (State or Foreign htry) YLAND
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD HOWARD		10c. City, Town or COLUMB					1	0d. Inside City Limits 1 X Yes 2 □ No
	th with the Marylan 23a or 28a-f ehow	Funeral Director	10e. Street and Number 6022 RIVERMEADO	WS ROAD		10f. Zip Code 210	45		10g. Citizen of USA	What Coun	itry?
036		by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Amed Forces? 1 ☐ Yes 2 💆 N If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		pecify Yes or No- Pican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, fy: B	
9500-61212	s 1 and 2 should be filed within 72 hours after de It Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Iteme other treumatic event, Ira Medical Examination	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2 T H	cation e completed) College (1-4or 5- 6 YEARS	-)	edent's Usual Occup re kind of work done DO NOT use retired		king	16b. Kind of B		,
yiand	nould be filed Mental Hyg narked other natic event,	To Be C	17. Father's Name (First, Middle, Last) ALBERT SUMMER				18. Mother's Nam	ne (First, Middle, A CLAR	Maiden Sumar	ne)	
, mary	and 2 sho selth and N n 27 is ma		19a. Informant's Name/Relationship (Type VERNA M. TOMLIN		UGHTER		VERMEAD				
baitimore	nit. Pages 1: vartment of He ortant: If iten injury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	METRO	position (Name of ematory or other plac CREMATOR	Y 6/1		20c. Location	VILLI	E, MD
מפ	Departition Depart		21. Signature of Euneral Service License	N. A	down	4600 LIB	ERTY HE	IGHTS A	AVE, B		ME 21207 MORE, MD
	Physician /Medical Examiner		23a. Phili Shier the disease, or complication of chear fature. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a	consequence of):	CVA	g, such as cardiac	or respiratory ari	rest,	/	Approximate Interval Between Onset and Death
,00790	rificate be executed ig physicien and as the burial-transit	Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):						
.O. BOX 0	Physician: The lew requires that the death certific this certificete has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)				te of deliver	ry Day Year
rds, r	en signed bould be deta	Ď	Part II. Other significant conditions cont	tributing to death but	not resulting in the $\mathcal I$	underlying cause give	en in Part I.		bacco use cont		e cause of death?
מו שבנסנ	ding Physician: The lew ro h. Affer this certificete hes be funeral director, page 2 shi	Completed						24a. Was a autops perfore	med?	Were autoporior to combeath?	sy findings available apletion of cause of
=	siciar certif recto	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Deatl				
5	Phys this rat di	٠ <u>.</u>	1 Yes 2 No	1 Inpatient			4 Nursing no	me 5 Heside			
	To the Hospitel or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Certification	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day	Year) 28b. Time Injury	M 1 🗆 Y	(? Yes 2 □No	28d. Describe ho			
2	pitel or A ours efter eral Direction by	i Certi	4 ☐ Homicide determined 29a. Certifier 1 ☐ Certifying Physical P	building, etc.	(Ѕресіту)			28f. Location (St City or Town	n, State)		
	To the Hospitel or Attencythin 24 hours efter death To the Funeral Director: completely filled in by the I	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physi 2 ☐ Medical Examine 29b. Signature and title of certifier	er: On the basis of e	xamination and/or it	occurred at the tim ovestigation, in my op	pinion, death occurr	ed at the time, di	ause(s) and ma ate and place, a ————————————————————————————————————	and due to t	the cause(s)
A			30. Name and address of person who con	nolated cause of the	and them seed to	7 D3	16942	_ \int \int \int \int \int \int \int \int	ine	20,	2006
J	Sta	6	31. Date filed (Month, Day, Year)	32. Resistrar	1, fred	wich Rd	afort	ville,	MO 2	122	-8
	Registr		1111 9 9 20		- K. K	marke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#26 PER PHYS. C856 6/22/06 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0624A M ATHENA RACHEL ROSEBORO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solta timore Cou 11) N/A 8. Date of Birth (Month, Day, Year) SEPT 7 197 Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Hours Director 238-19-2912 MARYLAND 1971 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show if Item 27 ie marked other then "naturel", or Iteme 23a or 28a-f shov or other traumatic event, the Madical Examinar must be notified at 1 TYes 2 No Director MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1509 W FAYETTE ST. APT B 21223 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXV0 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 2 Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade DISABLED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If tern 27 le marked o any Injury or other treasment. ould be f ဥ Gabriel Gene Roseboro Alice Rachel Singletary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelic C. Roseboro/Sister 1011 Pennsylvania Ave., Apt 301, Baltimore, Md 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 06-26-06 LANSDOWNE, MARYLAND 21. Signature of Funeral Service Lice 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mari /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence.bf) Examiner Box 68760, ~ burial-transit attending physician for use as the buria Vasceler Disease Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 4☐ Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Division of Vital 1 Yes 25. Was case referred to medical examiner?

Yes 2 No 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 Proutpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28c, Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending Natural 2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Baltmare INOVAN 2000. W 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

06-04206 James D. Rice

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 19720

			I- For State Registrar		Cei	rtificate of	Death			Reg. No.	000 1312
	ysicia	an/	1. Decedent's Name (First, Midd		-			*	2. Date of De	ath	3. Time of Death
ledical E	xami		Jame		L.	Rie	ce		June 17,		1827 nrs
")			4a. Facility Name (if not institute 814 Collington Ave G		umber)	41	Baltimore	Location of Dea	ath	4c. County of	Death NA
	neral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year				Birthplace (State or Foreign
Dire	ctor		215-72-0738	1 X M 2 F	5	54 Yrs.	Months Days	Hours N	in. 9-9-		Country) Md.
		ļ	Usual Residence of Decedent		 						
	w any	Ì	10a. State 10b. County		10c. City	, Town or Locatio					10d. Inside City Limits
land	28a-f show I at once.	ğ	Md.	NA		Balt	imore				1 X Yes 2 No
Many	r 28a	Director	10e. Street and Number	A	••-		10f. Zip Code	005		10g. Citizen of Wha	at Country?
ith the	23a o notifi		814 N. Collin			0 140 14/	212		2 10 10	USA	
15-0036 filed within 72 hours after death with the Maryland Hyviene	or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 N	lamed Armed I			Decedent of His s, specify Cuban,			14. Race - White,	American Indian, Black, etc.
ter de			3 Widowed 4 Di	1 Yes vorced If Yes, Give Ye	2X No ear	1 .	Yes 2 X No	specify:		Specify:	Black
wrs af	amin	d by	15. Decedent's Education (Spe	or Dates:		16a. Decedent'	s Usual Occupati	ion (Give kind o		16b. Kind of Busi	
72 hc	n "nz	Completed	Elementary/Secondary (0-12)	College	1-4 or 5+)		st of working life.	DO NOT use r	etired)		
036 vithin	Medic	m d	9th grade			Labo:	rer			Constr	uction
Iled v	d oth		17. Father's Name (First, Middle	e, Last) Amos		Rice	1		me (First, Middle nette	, Maiden Surname)	enkins
21215-0036 ald be filed within 7	narke	To Be	James 19a. Informant's Name/Relation.				Address (Street			umber, City or Town,	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Denarment of Health and Annual Hoviene.	fresh of from an investigation of the "natural", from traumatic event, the Medical Examiner		Jeanette Rice		ther	706	E. 23rd	Street	, Baltim	ore, Md.	21218
and Heal	er tra		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal		Place of Disposit crematory or other		netery,	Date	20c. Location - 0	City or Town, State
mo Page:	ant:		4 Donation 5 Other S		·	Greenmou	nt Cem.	6-	-21-06	Baltim	ore, Md.
Baltimore, permit. Pages t ar Denartment of He	inport	1	21. Signature of Funeral Service				me and Address	,	В	altimore,	Md. 21202
	_		France	1/2/0			arch F.H			l E. Nort	
Physi Med	ician dical		23a. Part I. Enter the disease, of failure. List only one cause	e on each line.		,			c or respiratory a	rrest, shock, or hear	Between Onset and
Exam			Immediate Cause (Final disease or condition resulting in death)		ive Atherosc	lerotic Cardio	vascular Dis	ease			Death
				b.	a consequence o	JI).					
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence o	of):					
		Examiner	(Disease or injury that initiated events resulting in death) Last	C	a consequence of	of):					
executed	nd ransit		events resulting in death) Last	d.	, , ,	,					
_ 0)	g physician and the burial - transit	n/Medical	UNPENDED	AMENDED							
8760, tificate be	physi the bu	Me	IF FEMALE: 23b. Was decedent pregnant in t		, outcome of preg					23d. Date of d	
68 certifi	nding se as	ian	past 12 months?	I	birth nant at time of de	2 Feta		Ectopic preg	nancy	Month	Day Year
Box 68 e death certi	/ the attending hed for use as	Physicia	1 Yes 2 No 9 Ur	nknown 9 Unk		eath 5 Othe	er (Specify)				
. =	5		Part II. Other significant condi	itions contributing	to death but not i	esulting in the un	derlying cause g	iven in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
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of Vital Records, ng Physician: The law requin	s been should	Completed							24a. Wa auto		ere autopsy findings available ior to completion of cause of
ecc he tav	2 a	ᇤ							peri		eath? Yes 2 No
<u> </u>	certificate ector, page	BeC	25. Was case referred to medic	al		<u>-</u>	26.Place	of Death (Ched	ck only one)	_ استما	
Vit	di Fi	9	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other Nur	sing Home 5	Residence 6	Other: Scene
of of	After the funeral	Ë	27. Manner of Death 1 ✓ Natural 5 Dear	28a. Dat (Mon	e of Injury h, Day,Year)	28b. Time of Inj	· 1 _ ·	y at Work?	28d. Describe	how injury occurred	d
SiOr Aftend	Director:	äţ	- Per	estigation				es 2 No			
Division Spital or Attendia spital or Attendia	Dire	Certification:		ild not be		ome, farm, street	, factory, office b	uilding, etc.	28f. Location or Town,		r or Rural Route Number, City
Ospita	ineral y fille		4 Homicide	(0,000.)					1		
Divi	To the Funeral Director: completely filled in by the	Medical	(Check only Certifying F	aminer:On the basis	of examination a					use(s) and manner a e and place, and du	
To the	To	Med	29b. Signature and title of certifi	and manner er	stated.		29c. License	number		29d. Date signed	d (Month, Day, Year)
		_	his his	mi			O.C.N			June 19, 20	
,			30. Name and address of perso		use of death (Item	n 23a)					
3				ant Medical Exa		Penn Street	, Baltimore, I	MD 21201			
	S	tate	31. Date filed (Month, Day, Sea	ă â	enistrar's Signat	3	1				
			LIGHT		Company of						

			1 - For State Registrar	State of Maryla	and / Depa		ealth and M	ental Hygi	ene g. No? [] []	6 1972 I
	Physici		Decedent's Name (First, Middle, Vicente	Last) Fortis		Roca	9	2. Date of Death Month June	Day Y	3. Time of Death 2006 5:00 P
	/Medi Examir		4a. Facility Name (If not institution,			1	Location of Death	Julie	4c. County of	
			7941 Elvaton Ro	ad		Glen Bur	nie		Anne Ar	runde1
	Funeral		5. Social Security Number	. X	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) g	Birthplace (State or Foreign Country)
	Director		572-86-3263 Usual Residence of Decedent	18M 2LIF 89	Yrs.			April 9,	1917 Ph	nilippines
	land ow		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary Fig.	ş	MD Anne Ar	unde1 G1	len Burn	ie				1 ☐ Yes 2 🛣 No
	or 28s	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?
	23a c	aic	7941 Elvaton Ro	ad		21061		τ	J.S.A.	
	tems	nuel	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)		American Indian, White, etc.
Maryland 21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Examinar mark he notified at	þ	1 ☐ Never Married 2 ⚠ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Asian
Ö	2 hou	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occupa	ation	11	6b. Kind of Busin	ness/Industry
215	thin 7	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)			luring most of workir			•
21	filed with Hygiene. other than	Completed		4	Civil	Engineer			Baltimor	re City
nd	tal H	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
yla	Meni Meni Marke Marke	ို	Amancio Roca					ınknown)		
Mai	12 sho h and 7 is ma trauma		19a. Informant's Name/Relationship				nd Number or Rura			
	1 end Heelt em 2 ther		Mrs Carmelita F 20a. Method of Disposition		/941 D. Place of Dispo		Road Gler			061 ty or Town, State
Baltimore,	permit. Pages 1 end 2 Department of Heelth a Importent: if Item 27 is any Injury or other tra <u>900.e</u> .		1X Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, crer	natory or other place	Journe	23,		
Ħ	artme prten Injury		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lin			n Mem.Par				rnie, MD
Ba	Dermi Depa Impo any I		1/ the		707911		enue Sw G	-		Home, P.A.
	Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	ly one cause on each line.		er the mode of dying				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a cons		7				
	cuted	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):					
8760,	ate be exe hysicien a the burial-t		resulting in death) Last	Due to (or as a cons	equence of):					
P.O. Box 68	The law requires that the deeth certificate be executed ale hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
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Vital	icien: Th certificete rector, pag	40	25. Was case referred to medical				26. Place of Death	1 Yes 2	J No 1□	Yes 2□ No
<u> </u>	Physicien: The this certificate he ral director, page	70 B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe			e 6 □Other /	(Specific)
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Division	27. Manner of Death 1 Plantural 5 Pending investigation 2 28d. Describe how injury occurs of linjury 28d.				et and Number of State)	or Rural Route Number,				
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Medical	one)	Physician: To the best of my k aminer: On the basis of exami and manner stated.	nowledge, death nation and/or inv	restigation, in my opi	nion, death occurre	nd due to the caus d at the time, date	se(s) and manne and place, and	er as stated. due to the cause(s)
	To To Conn	2	29b. Signature and title of certifier	~ WE	>	29c. License	15346 5	290	1 -1	fonth, Day, Year)
2	0		30. Name and address of person wh		em 23a) (Type, I			عم ري	en Por	21061
	Sta		31. Date filed (Month, Day, Year)	32 egistrar's Sig	nature	action				

DHMH 17 Rev 1/2001

			For Stata Registrar	State of Ma			nt of Hea	ilth and M		-	06	19722
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, とけみんしょう 4a. Facility Name (If not institution,	JAM 23	217			cation of Death	2. Date of Death Month 06 - 17	Day	Year 6	3. Time of Death 1 イニ3分 M
	Funeral Director		215-68-5739		e (In yrs. last birt	स्र ८	r 1 Year If t	Under 24 Hrs.	8. Date of Birth (Month, Day, 1)	H A A	conc	ce (State or Foreign
	ith the Maryland or 28s-f show	Director	Usual Residence of Decedent 10a. State 10b. County Md. Harf	ord	10c. City, Town		ardiff					I. Inside City Limits 1 ☐ Yes 2X No
	death w	Funeral	1619 Main Stree 1. Marital Status 1. Never Married 2. Marrie	12. Was Decedent E Armed Forces? 1 ☐ Yes 2√2 N		13. Was Dece		nic Origin? (Sp <i>e</i> exican, Puerto F		Harfo	What Country ord e - American ck, White, etc.	Indian,
3 <i>§</i> 21215-0036	within 72 hours atter ene. than "natural", or ite ine Meolical Exemine	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)	If Yes, Give Year or Dates: Education grade completed) College (1-4or 5		1 ☐ Yes Decedent's Usu (Give kind of wo	al Occupation	pecify: g most of workin	16	Specify 6b. Kind of Br	v: wh	nite
9 and	permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Monte.	To Be Co	9 years 17. Father's Name (First, Middle, La Charles J. Rine 19a. Informant's Name/Relationship	hart, Sr.		on work	18.	Evelyn	(First, Middle, Ma Louise	_{liden Suman} Leonar	:d	
40	permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau		Shawn Rinehart/ 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	SON □Removal from State	20b. Place of cemetery	010 Carr Disposition (Nai	ne of other place)	Road,		, Md.	21047 City or Town	ı, State
Baltin	permit. P Departme Important any injury once.		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lic 23a. Part1. Enter the disease, or conshock, or heart failure. List or	ensee	-	22. Name ar Schim	nd Address of I	6/21/2 Facility uneral 1 hail Ros	Home of	Bel Ai	more, r, Inc	
- Obak47 8760,	are be hysicia he bui	lical Examiner	23a. Partit. Enter the disease, or conditions, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. 1-1 0 Due to (or as a b. Due to (or as a	consequence of):):			respiratory arrest		Int	oproximate terval Between nset and Death
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S Jew	as been signed to 2 should be dett	eted by P	Part II. Other significant conditions	contributing to death but	not resulting in	he underlying ca	ause given in F	Part I.	23e. Did tobac		bute to the ca	
	certificate has rector, page 2.	Be Completed	25. Was case referred to medical examiner?				26. F	Place of Death (24a. Was an autopsy performed 1 Yes 25 Check only one)	1/ O	Vere autopsy for to comple eath?	findings available ation of cause of
ision of Vita	After this tuneral di	၉	1		Yea <i>r)</i> 28b. Tir	М	A Other: 4 [8c. Injury at Work? 1 Yes	Nursing Home 28	e 5 ☐ Residence d. Describe how i	njury occurre	bd	
Zinehal Division	within 19 hours after death	edical Certification:	4 Homicide determine 29a. Certifier 1 Certifying R (Check only 2 Madical Ext	Physician: To the best of aminer: On the basis of e	my knowledge, examination and/	feath occurred :	at the time, date	to and place and	f. Location (Stree City or Town, S	tate)		
	within 2 To the complei		29b. Signature and title of certifier	and manner state			License numb		29d.	Date signed	(Month, Day,	Year)
6			30. Name and address of person who $G - S P A B H U$	completed cause of dea	ath (Item 23a) (Ty	/pe, Print)	> T.	MO NI	JM MS			
	Stat Registra	-	31. Date filed (Month, Day, Year)	2006 32. Ragistrar	s Signature	Sparte	•					

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla			ent of He ate of De		d Mental H	Hygiene Reg. No	600	6 19	723
	Physici /Medic		1. Decedent's Name (First, Middle, Las	t)		5	KALS	ON S	2. Date of Month	Da		17	of Death 2 4 M
	Examin Funeral Director		4a. Facility Name (If not institution, give 5. Social Security Number 61Se 218-76-6485	Kins Hospit	s. last birthday	Ba	er 1 Year I	ocation of De) (C If Under 24 H Hours M		Birth Day, Year,	9. E	Birthplace (State Country)	
	D	ctor	Usual Residence of Decedent	10c. (City, Town or L len Bur				16/3/	1333		10d. Inside	
	ath with th	ral Director	10e. Street and Number 801 Castle Road				Zip Code 1061				tizen of What		
		by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. 13	If Yes, s	pecify Cuban,	anic Origin? Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-	Black, W	merican Indian, hite, etc. Vhite	
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ylarıd z	should be filed nd Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Glen Skarson					Anita	Name (First, Mid M. Sten	dle, Maidei g1e	n Surname)		
e,	s t and 2 shoul Health and M tem 27 le marl other traumati		19a. Informant's Name/Relationship (7) Catherine A. Skars 20a. Method of Disposition	son/spouse		Cast	le Road		n Burni Date	e, MD			
Saltimo	permit. Peges 1 am Depertment of Heal Important: If Item 2 eny injury or other once.		1 Burial 2 XCremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Liter)) Memoval from State	etro Cr	emat	Ory, In	of Conilina	-/7-06 Stalling		timore, neral H		Α.
	Physician		23a. Part 1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. BRAIN AB	cess	311 nter the m	1 Mount ode of dying, s	<u>tain R</u>	d. Pas	adena	, MD 21	Approxim Interval B Onset and 5 7 D	ate etween d Death
3700,	cate be executed by State of the physicien and care the purial-transit	dical Examiner	f	b. CY ANDTIC + Due to (or as a cons c. Pullunity Due to (or as a cons d.	HEDRET equence of): ATTUES	DISE	MTH"	VSD" o	VENT IR SEPT	picui M DI	AN EFECT	46 VE	EARS ARS
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ion or	ding Ph h. After th funeral		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		of	28c. Injury at Work?		28d. Descri			ecny)	
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•	h		30. Name and address of person who o	completed cause of death (It		, Print)					E 15, 2		
	Sta	te	KEVIN WOODS THE 31. Date filed (Month, Day, Year)	JOHNS HOPKI	nature 4	MAL	600 1	10 May 1	WOLFE ST	REET,	BALTIMOIL	e maryu	tn0212597
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WEVIN A. SEWELL 06-04076 UNK UNK

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CONK		1-For State Registrar State of Maryland / Department of Health and Menta Certificate of Death		eg. No. 200	16 1972
Physici: Exami	an/	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month June 13, 2	th Dav Year	3. Time of Death 2255 hrs
A		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of I Sinai Hospital Baltimore		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2		th(MM/DD/YYYY) 9. Bir	thplace (State or
Director	d	214-15-4269 1 M 2 F 19 Yrs. Months Days Hours Usual Residence of Decedent	Min. 05-6		puntry) Mq.
ж апу		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show dat once.	Director	10e. Street and Number 1 10f. Zip Code	11	0g. Citizen of What Cou	1 Yes 2 No
ith the N 23s or notified		14 70 0 .	7	US	>A _
or items	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, P		- 14. Race - Amer White, etc.	ican Indian, Black,
ours after atural", aminer	þ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kin		Specify: 16b. Kind of Business/	Industry
e, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho tranmatic event, the Medical Examiner must be notified at once.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT us	se retired) NA		NA
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2121 hould be find Mental is marked tic event,	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	er or Rural Route Num	nber, City or Town, State	e, Zip Code)
e, MD I and 2 shu Health and item 27 is		Cynthia Mc Donald - mother 1609 Bakbury C 20a. Method of Disposition (Name of cemetery)	t. Bale	Amore, m	d, 2/2/7 Town, State
는 S 는 를		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	6-26-06	Dunda	eff, md.
Baltimo permit. Page Department Important: injury or ot		21. Signature of Funetal Service Licensee 22. Name and Address of Facility Company of Funetal Service Licensee	270 Fed		Pasa eto, md, 2122
ysician Medical		23d. Pert of the disease, or complications that caused the death. Do not enter the mode of dying, such as card lail disease, on each line.	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to the Head Due to (or as a consequence of):			Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause b. Due to (or as a consequence of):		·	
F	Examiner	CDisease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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ivisior or Attence after death Director:	ertification	2 Accident Investigation Jun 13, 2006 2230 hrs 1 Yes 2 N N Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S		ural Route Number, City
Div lospital or l hours afte uneral Div ly filled in	ပ	4 V Homicide determined (Specify) Local Street		Towanda Avenue	
To the Hospital within 24 hours a To the Funeral completely filled	ledical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the caus urred at the time, date	and place, and due to th	ne cause(s)
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo June 14, 2006	nth, Day, Year)
7		30. Name and address of person who completed dause of death (Item 23a) Susan Hogan MD Assistant Medical Evaminer 111 Popp Street Rollimore MI	D 21201		
St	tate		D 21201		
Regis	trar	JUN 2 2 2006 Steven & Specific			

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	Funeral		5. Social Security Number	6. Se	9x 7. □M 25√2 F		. last birthday)	If Unde Months	r 1 Year Days	If Under :	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)	9.	Birthpl Count	ace (State or Foreign
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É	if or Atter efter dea Director	Certification;	3 Suicide 6 □ Co	uld not be ermined	28e. Place of building,	njury - At h etc. (Speci	ome, farm, stre	et, factor	y, office		2	t8f. Location (S City or Tox	Street and vn, State)	d Number or	Rural I	Route Number,
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	2		30. Name and address of per-	11 1 4 5 -	ompleted cause o	death (Iter	m 23a) (Type,	Print)	- I	00	· ·	3	41x	Inco	MI	7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1,perM1,0856,6/26/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Frances LesLie Seidel 2. Date of Death 3. Time of Death Month 2006 Frances Leslie Siedel June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Aug. 8, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2**X**) F Months Days Hours Min. 82 Yrs. 1923 Maryland 216-18-7196 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 □ No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1714 Wilkens Avenue 21223 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status I Yes 2 Mo I Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lidva O'Neil Unknown Arnold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Prandson 255 Wanda Road, Pasadena, MD 21122 Frank Anthony Garbo, Sr. 20a. Method of Disposition
1 € Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State New Cathedral 6-24-2006 4 □ Donation 5 □ Other (Specify) Baltimore, MD Cemetery 21. Signature of Funeral Service Licenses 722. Name and Address of Facility Ambrose Funeral Home, Inc. /1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiorg Due to (or as a consquerce of) te TOTA Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 mor Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown MUDICUR Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Yes 2 No Yes 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 🗆 Yes 1 Impatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one)

The law requires that the death certificate be executed FRanc Records. Attending Physician: Division ō the Hospitel

Physician

/Medical

Examiner

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28a-f show

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Baltimore, Maryland 21215-0036

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Registrar DHMH 17 Rev 1/2001

State

of death (Item 23a) (Type, Print)

. Registrar's

29d. Date signed (Month, Day, Year)

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e, IV 1 and 1 and Health em 27	1	20a. Method of Disposition	rere / Son	20h Place of Dispo	KOCKDUTI	n Drive	, Ellic Date		City MD 2.	
Pages 1			☐Removal from State	20b. Place of Dispo cemetery, crea	matory or other pl	ace) J	une 24,	20	oc. Location - City o	r rown, State
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DIVISION To the Hospitel or Attent within 24 hours after deati To the Funeral Director: completely filled in by the	Medicai	one)	and manner state	d.						
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1)		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type,	Print) Dr.	Charle	s Wu			
10		1600 S. Crai	n Hwy St	e. 106,	Glen	Burn	ie, M	D 3	71061	
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Physician / Medical Examiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of): Sequentially list conditions, if any, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Pedicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
(Wallace Uns) 3/136 JUNE 21 2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
BRIAN C. WALLACE MD, 9005 KILBRIDE RD, BALTIMORE, MD 21236	>
29b. Signature anothitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN C. WALLACE MD, 9005 KICBRIDE RD, BALTIMORE, MD, 2123 (State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🕤 1 - For State Registrar Certificate of Death SINGLETARY 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 11:30 PM RUTH Physician 2006 JUNE 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Mariner Health & Rehab - Catonsville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Sep 18, 1932 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6 Sax 5 Social Security Number **Funeral** 1 M X F No. Carolina Director 245-58-1273 73 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 27 is marked other than "natural", or Itams 23a or 289-f show traumatic event, the Medical Examitrar must be notified at 1 Yes 2 □ No **Baltimore** N/A Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code with 21229 U.S.A 15 South Tremont Road death by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Menial Hyglene. Importent: If Item 27 is marked other than "natural" ~ " any injury or other traumatic even." 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Amed Forces? Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Yes, Give 1 ☐ Yes 2X No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Rancey Eley ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 South Tremont Road Baltimore, Maryland 21229 Mitchell Singletary Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/20/06 Baltimore, Md. Western Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACCIDENT a. CEREBROVA SCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only 29d. Date signed (Month, Day, Year)
JUNE 15 2006 29c. License number and title of gertifier PHYSICIAG 29b. Signatura 42723. JUNE 15 ROAD OLD COURT SUITE ress of person who completed cause of death (Item 23a) (Type, Print) 9310 30. Name and add AVVERAHALLI RANDALLSTOWN 32/Registrar's Signature 31. Date filed (Month, Day, Year) CONE! State Busse JUN 2 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10,2006 JUNE **Physician** MARY STABILE 3:43 p M /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RIVERVIEW NURSING HOME BALTIMORE ESSEX 8. Date of Birth (Month, Day, Year)
.TAN . 10,1921 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 219-18-4094 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 □ No Director N/A BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 435 S. ELLWOOD AVENUE 21224 or itams 23a U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced WHITE "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ith and Mental Hygiene. 27 is marked other then "r r traumatic event, the Mod Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER BUDEKE PAINT CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental hy Important: if Itam 27 is marked oth any injury or othar traumatic avent one. Be STANISLAUS STABILE TROTTA MARY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21221 19a. Informant's Name/Relationship (Type, Print) VICTORIA FLEISCHMANN/SISTER 1000 FRANKLIN AVENUE, APT. 618, ESSEX, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) OAK LAWN CEMETERY 6/13/06 BALTIMORE, MARYLAND 21. Signature of Funeral Bergies Licensee 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
700 S. CONKLING ST., BALTO., MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heert failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) un-Known duante **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\sqrt{Nursing Home} \) 5 \(\sqrt{Residence} \) 6 \(\sqrt{Other} \) (Specify) 1 ☐ Yes 2 ☑ No ဥ the state of within 24 hours after death.
To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-387-54 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN BLUD, MD-21221 LAS BRAM 709. 31. Date filed (Month Rev2 2 2006 32 Registrar's Signature State Riberus D Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 18ay 2006 ear 7:35 p M Joyce Ann Morton Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Balto 3922 Nemo Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 5-18-1947 5, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Days Hours Min. 218-48-2025 59 Md Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or liems 23a or 28a-f show other traumatic event, the Madical Exempter must be notified at 1 Yes 2 No Director Balto Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 USA 3922 Nemo Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) 12th grade Verizon Secretary and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Lola Garnett Benjamin Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If Itam 27 Is any injury or other traugnce. Anthony L. Thompson - Husband 3922 Nemo Road Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Druid Ridge Cemetery 6/23/2006 4 Donation 5 Other (Specify) Balto, Md of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, MD 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final 10 gy **Physician** sease or condition esulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been : 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? After this certificate 2 No 1 Yes 2 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 3 DOA ome 5 Residence 6 □Other (Specify)
28d. Describe how injury occurred Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 1 A Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funaral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Owines Mices, MD 2011) DR-#325, CYOSSROADS 31. Date filed (Month, Day, Year) State JUN 2 2 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** ule June 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5T. Agnes 5. Social Security Number 250-32-6863 Hospital Itimare 8. Date of Birth Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1□M 2XF Months Days Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State ral', or itema 23a or 28a-f shor Examiner must be notified at Baltimore 1 ☐ Yes 2 No md, Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S riarwood 2122 death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Blac 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 7 is marked other then "nature traumatic event, the Medical 16b. Kind of Business/Industry Josepi College (1-4or 5+) Elementary/Şecondary (0-12) Hospital nurse IA 17. Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental BURKet Mary Simpson -ong 19b. Mailing Address (Street and Number or Rufal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth a Important: If item 27 is any injury or other train once. 53 daughter 200. Place Briarwood Rd. Ivey coperatonsville md, 21220 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Hrbutus mem. PK. -06 22. Name and Address of Facility W. Fa 21. Signalure of Funeral Service Licenses Errect Mancymi wallace runca Jenice Daeto, md, 21229 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mile of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3x 1xce Heart Physician 10 m in /Medical ordio vascular Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ormed? 2 Al No this certificate 1 Yes Division of Vital After this certification funeral director, p Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 Proutpatient 3 DOA Certification: To 1 Inpatient 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined within 24 hours after dea To the Funeral Directo completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifies

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

pleted cause of death (Item 23) (Type, Print)

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTFM/17 PER FH, G857, 7/6/06 WS
State of Maryland / Department of Health and Mental Hygiene () () () 1 - For State Registrar Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AM Month Yea **Physician** 5 2000 THOMPSON 0 ELIA. /Medical 4d. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Hospital ENTR Vorth West If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 M 2 F 216-26-7747 Usual Residence of Decedent Yrs. Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State ?7 is marked other then "naturel", or items 23e or 28e-1 show treumatic event, It a Medical Examinar must be nutilised at Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2609 HVe burn 21215 death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ☐Yes 2V No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates: Specify: 4 Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene. Classics Elementary/Secondary (0-12) College (1-4or 5+) 12+1 Shipping 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be and Mental I HAYWOOD R. SAUNDERS Jarrie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Inform nt's Name/Relationship (Type, Print) 4000 Prose Crast Ave Baltimore f Health item 27 I Md nence Holton Daughte othar 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. un Cemetery 16/23/06 Woodland 22. Name and Address of Facility Charmen - Harri Woodlawn Cemetery Woodlawn * 4 ☐ Donation 5 ☐ Other (Specify) 5 Funeral Home 21. Signature of Funeral Service Licenses 5240 Preisterstown Ad Battimore arris cros 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PANCREATIC Immediate Cause (Final META STATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 12 y, 132 fig to 1111 scales cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed page 2 should peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 1 Yes certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 2 □No death. М 1 Tes within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier m.c D41410 JUNET 2 2006 U 7 JOGINDERP MENTA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 SPITAL CEN 32. Registrar's Signature 2006

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31. Date filed (Month, Day, Year)

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ANDAUS TOWN MO

Phillip Douglas Tyndell Baltimore, Maryland 21215-0036

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	/Medic Examir	2,5	4a. Facility Name (If not institution, give :						r Location of Death		4c. Count	y of Death	
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	Funeral Director		5. Social Security Number 6. Sex 266-2177-56	M 2□F	50	last birthday Yrs.	Months		Hours Min.	8. Date of Bird (Month, Da Apr 23	y, Year)	_ Cou	^{place (State or Foreign} ntry) humpaka FI
	land land		10a. State 10b. County		10c. City	y, Town or l	ocation						10d. Inside City Limits
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	or 28	Director	10e. Street and Number	_				708			10g. Citizen of	What Cou	intry?
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Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show amy injury or other traumatic event, the Medical Exam marmual be notified at ance.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 ! If Yes, Give Year or Dates:	Non 9 /	79	Il Yes, sp	ecify Cub	an, Mexican, Puert	o Rican, etc.)	Bla	ack, White, Bla	, etc.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 5 per of health and Mental Hygiene State Registrar Amend #20b Per FH G856 6/28 Pertifinate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month H: 500M **Physician** 06 FREEMAN WILEY ROY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BO-HIMORE HOSPITA MOSECIALE
If Under 1 Year | If Under 24 Hrs. la GUARE tranklin 5. Social Security Number 238 - 6369 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Hours 1 XM 2 ☐ F Yrs. 74 NORTH CAROLINA Director Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Tyes 2 No Director MARYLAND BALTIMORE ESSEX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1326 GOODWOOD AVENUE 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 10th grade TRUCK DRIVER SHILLERS FURNITURE or other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 and Mental NANNIE PULLIAM WILLIAM WILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Heelth a Janie Wiley/Wife 1326 Goodwood Ave., Baltimore, Maryland 21221 20b. Place of Disposition (Name of Kingment Memoring & bind Parcel Date 20a. Method of Disposition Baltimore, Md. 1 ∑Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS MEMORIAL 06-24-06 MIDDLE RIVER, MARYLAND 21. Signature pral Spring icen 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Rolle 1206 W NORTH AVENUE Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain **Physician** Stem /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infriedlats cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) Examiner physicien and s the burial-transit or Attending Physiclan: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. To Be Completed by Physician/Medical as IF FEMALE: nse nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cardiomyopath nemic autopsy performed? Yes 2. No certificate 1 Yes 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) es D53694 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Squaredr. Baltimore, MD 21237 ShinnER 9000 Franklin 5 Danie

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State Registrar 31. Date filed (Month, Day, Year)
JUN 2 2 2006

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32. Registrar's Signature

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/Medica	al .	Milton J. Wehr Jr.			1 1 1 1	June 2		
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Funeral Director		217-32-9229 1 1 M 2 F	Age (In yrs. last birthday) 68 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Feb. 21	Year) 1938 Co	hplace (State or Foreign
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Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filled within 72 hours attraction of health and Mantal Hygene. Mportant: if item 27 is marked other than "natural; or my injury or other traumatic event, the Micale Elections.	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired	during most of work	ing 1	6b. Kind of Business	Industry
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10		30. Na nd address of person who come eted cause	of death (Item 23a) (Type	e, Print)	OEOE	Zaca CI	BriAn	0 21707
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06-04116

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Gary G Williams 1- For State Certificate of Death Rea No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ June 15, 2006 0058 hrs **Medical Examiner** ran liams 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (not institution, give street and number) Good Samaritan Hospital Baltimore If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director Country) 217-76-674 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No 28a-f shov osedale 1a Kultimore hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2123 USA 540 items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes No Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2 No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages 1 and 2 should be filed within 72 I Department of Health and Mental Hygienc partment of Health and Mental Hygenc portant: If item 27 is marked other than ' ury or other traumatic event, the Medical Baltimore, MD 21215-0036 anitor 19+4 18.Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Williams yan to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ Corkley Rd Rosedale Md Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place)
Trainity Cemetery 1 Burial 2 Cremation 3 Removal from State 21 106 Dundalk Donation 5 Other Specify (a.mel 22. Name and Address of Ficility ature of Funeral Selice Licenses 5240 Reisterstown Rd Baltimore Approximate Interval Between Onset and Part I Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Physician failure. List only one cause on each line /Medical Death Liver Cirrhosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, ner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of) item#20b,23a,PII,27,perME,g856,6/26/06 TI Physician/Medical AMENDED X UNPENDED ending physician a Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ Hypertensive atherosclerotic cardiovascular disease; terminal 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an renal disease prior to completion of cause of autopsy certificate has performed? 1 ✓ Yes 2 I death? 1 🗸 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this (٥ 1 V Yes After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending Funeral Director: the Accident Investigation 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide (Specify) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 15, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1- State Recistrar Amend #8 Per FH G857 7/03/06C Hificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death WOOD **Physician** JOEANN 2300 PM JUNE /Medical 4a. Facility Name (If not institution, give street and number) CENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKING BAYVIEW MEDICAL BAUTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)1941 **Funeral** Days Hours 1□M 2€F 65 $14, \frac{1961}{1}$ Director June MD 213-36-2044 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show the Madical Examinar must be notified at 1 ☐ Yes 2 XNo Funeral Director MD Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21222 USA 2963 Liberty Parkway 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Waitress Restaurant as 1 and 2 should be filed voll Health and Mental Hygie litem 27 is marked other if other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Liberto Edna Unknown Liberto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle Bryan - Daughter 319 Oella Avenue, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Peges 1 1 Burial 2 Ferenation 3 Removal from State = 5 permit. Pege Department of Important: If eny injury or once. Bayview Crematory6-16-06 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility $Bradley-Ashton\ Funeral\ Home$ 21_Signature of Funeral Service Licensee PA, 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 DAYS HYPOXEMIA /Medical DISEASE Due to (or as a consequence of): Examiner YEARS CHRONIC OBSTRUCTIVE PULMONARY SEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Dther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Dey, Year) RES -000 JUNE 15, 2006 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE, MD 21224 JACOB DR. SNEHA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 2 2006 Registrar

			For State Registrar		State of Ma	aryland /		artment of F rtificate of	Health and N <i>Death</i>	Mental Hy	ygien Reg. N	Eine Col	06	1973
ı			Decedent's Name (F	First, Middle, Las	st)					2. Date of D Month		ay	Year	3. Time of Death
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,	Examir		4a. Facility Name (If no	ot institution, give	e street and number)			4b. City, Town, o	or Location of Death		4	c. County o	f Death	
			CARROLL	HOSPI	TAL CENTI				INSTER			CARR	OLL	
	Funeral		5. Social Security Num	1	ex 7. Ag □M 2127 F	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth ay, Yea	r)	9. Birthp	lace (State or Foreigr try)
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	r dea	Funerai	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or N Rican, etc.)	lo-		- Americ	an Indian, etc.
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	ding Physicien: The Ih. After this certificete he funeral director, page	ü.	27. Manner of Death 1 2 Natural	5 Pending	28a. Date of Inju (Month, Da	ry y Year) 28t	D. Time o	Wo		28d. Describe	how inj	ury occurre	d	
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	efter of Al	Certification;	4 🗌 Homicide	determined	building, et	ury - At nome, c. <i>(Specify)</i>	ramı, sti	eet, factory, office		City or To			r or Hura	l Route Number,
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State Registrar

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		•	For State Registrar	State of N	1arylan		artment of H tificate of L		Mental Hyg	iene g. No. 20	06	19740
			Decedent's Name (First, Middle	e, Last)		-			2. Date of Deat Month		rear	3. Time of Death
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H	Funeral Director		5. Social Security Number 212-38-5524	6. Sex 7. A	100	last birthday) Yrs.	Il Under 1 Year Months Days	If Under 24 Hrs Hours Min		, 1905	9. Birthpla Countr	ce (State or Foreign
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Š į	2 hor	ted	15. Deceden	t's Education		16a. Dece	ient's Usual Occup	ation	atrina .	16b. Kind of Bus	iness/Indu	istry
Maryland 21215-0036	be filed within 72 hours after tal Hygiene. d other than "neturel", or its event, the Medical Examina	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4o	r 5+)	Teach	kind of work done of DO NOT use retired ICI)		Penn Av	e. Sc	hool
and	ld be file lental Hyg ked othe Ic event,	To Be C	17. Father's Name (First, Middle, George W. A						me (First, Middle, M S.R. Apple)	
Mary	and 2 should salth and Men n 27 le marke er treumatic		19a. Informant's Name/Relations Peggy Leer	hip (Type, Print) frie	nd	19b. Mailir 301	Grand Av	and Number or R	dural Route Number, Cumb	City or Town, S erland	tate, Zip C	21502
w	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Ie marke eny injury or other treumatic: angog.		20a. Method of Disposition 1		_ C	emetery, crer	sition (Name of natory or other place emetery	e)	Date 6/22/2006	Cumbe		n, State
Balti	Departm Departm Importe eny inju		21. Signature of Funeral Service	Licensee	sell.	22	Name and Address Scarpe 108 Vir		Home, PA ue: Cumber	land MD:	21502	
П			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cavs only one cause on each	ed the death	h. Do not ent					1	Approximate nterval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aDue to (or a	as a conseq	uencerdi):	Twe	Hellin	rall	eu C	- 1	392
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8760, 5	icate be executed physicien and s the burial-transit	dical Exa	that initiated events ' resulting in death) Last	Due lo (or a	as a conseq	uence of):						
89 x	ertificate fing phys e as the	Medi	IF FEMALE:	23c. If yes, outcon	no of program							
P.O. Box	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours eiter death. To the Funerel Director: After this certificate has been signed by the eitending physicien and To the Funerel Director: After this certificate has been signed by the eitending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant 9 Unknown	2 Feta at time of d	I death 3	Ectopic pregnancy Other (specify)			23d. Date Mont		/ Pay Year
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Division of Vital Records,	ding Phy th. : After this funeral d	ıtlon; To	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date of Ir (Month, I		28b. Time of Injury	28c. Injun Work		28d. Describe ho			
Divis	al or Atter efter dea l Director d in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of	Injury - Al ho etc. (Specif	ome, larm, str	eet, factory, office		28f. Location (St. City or Town		or Rural	Route Number,
	To the Hospital or Attending Physicien: The within 24 hours either death. To the Funeral Director: After this certificete his completely filled in by the tuneral director, page	Medical C	29a. Certifier (Check only one) Certifying Certifying	ng Physician: To the be Examiner: On the basis and manner	of examina	owledge, deat ation and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the ca curred at the time, da	use(s) and man ite and place, an	ner as stated	ted. he cause(s)
	To the To the comp	W	29b. Signature and title of certifie	1 E S	Huit	dom	29c. Udens	6333	3	Od. Date signed	(Month, D.	ay, Year)
	12		30. Name and address of person	who completed cause of	I death (Item	(13a) (Type,	Print)	Figh an	Ta G	Marie	the	502
	Sta Regist	ate rar	31. Date filed (Month, Day, Year	2 2006 3275	strar's Sign	AG 9						

			For State Registrar	State of Maryla		artment of H tificate of I		Mental Hy	giene Reg. No.	2006	19741
			1. Decedent's Name (First, Middle, Last,					2. Date of De Month	aath Day	Year	3. Time of Death
	Physicia /Medic		William Jean Arqu	in				June	4	2006	
1	Examin	er	4a. Facility Name (If not institution, give			_	r Location of Deat	th		County of Deat	
			Manor Care Health 5. Social Security Number 6. S		s. last birthday)	Potoma If Under 1 Year		8. Date of Bi		ontgome	ry hplace (State or Foreign
Е	Funeral Director			M 2□F 84	Yrs.	Months Days	Hours Min	June 2	av. Year)	Co	untry) Lgium
	PL .		Usual Residence of Decedent	100 (City, Town or Lo	antion					10d. Inside City Limits
	ehov	7	10a. State 10b. County			Callon					1 ☐ Yes 2X No
	the M	Director	Virginia Fairfax 10e. Street and Number	County M	cLean	10f. Zip Code			10g. Citiz	zen of What Co	untry?
	3a or	i D	1821 Kirby Road			22101			U.S.A		
	deeth	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No	p- 1	14. Race - Ame Black, White	
9	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ♠ No If Yes, Give		1 □ Yes 2X No	Specify:	to thous, otely		Specify: Cau	
Ö	hours ture?	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	16a Deced	ient's Usual Occup	ation		16b Kin	nd of Business/	Industry
7.	n "na	Completed	(Specify only highest grad	e completed) Cotlege (1-4or 5+)	(Give	kind of work done o	durina most of wo	nking			
212	d with giene er the	mo	Elementary/Secondary (0-12)	-2-	Nurser	yman/Land	dscaper		Land	dscapin	g
g	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden :	Sumame)	
₹	Men Marke Marke	မ	Fernand Arquin	- Gried	40h Maille		Mathilde			Town Chair	To Code 1
Maryland 21215-0036	d 2 st th and t7 ts r traur		19a. Informant's Name/Relationship (T) Nora N. Arquin -			ng Address <i>(Str</i> eet L K ir by R					ip Code)
ē,	f Heal f Heal item 2		20a. Method of Disposition	20b	. Place of Dispo			Date		cation - City or	Town, State
altimore,	Page nent o int: if		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Met		Crematory	· 1	8,2006	Alex	andria	, VA
Balti	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23s or 28s-1 show eny injury or other traumatic event, the Medical Exercities round be notified at once.		21. Signature of Funeral Service Licens	EIMM		Name and Addre	U	efferson			-
			23a. Part1. Enter the disease, or compl shock, or heert failure. List only o	ications that caused the de	7					la, va 2	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Str	oke						Onset and Death
1	/Medical		resulting in death)	Due to (or as a cons	O I I						
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b	navianae of).						
_	ted nsit	nlner	Cause (Disease or injury	Due to (or as a cons	equence or):						
Ć,	execu n end ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a cons	equence of):						
8760,	cate be executed physician end ; the burial-transit	dical		d							
9	ntifica ing ph e as th		IF FEMALE:								
Вох	that the death certified by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	etal death 3	Ectopic pregnancy	1		2	3d. Date of del	ivery Day Year
0	the de y the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	rdeath 5	Other (specify)					
۵.	res that I	by Ph	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
rds	v requires been sign should be	ed b						1 🗆	Yes 2□]No 3∏Pr	obably 4 🗗 Unknown
900	S 5	Completed						24a. Was			topsy findings available completion of cause of
Ĕ	w	Com						perfe	ormed?	death?	2 /2 (No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only	one)		
of Vital Records,	ding Physician: h. After this certific funeral director.	٠ <u>۲</u>	1 Yes 2 No	1 ☐ Inpatient 2	☐ ER/Outpatien 28b. Time of		42 Indising	Home 5 ☐ Res 28d. Describe			cify)
0	Attending r death.	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		Wor	k?` Yes 2 □No	100.000.00		33331133	
Division	or Attendefer death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, str	eet, factory, office		28f. Location	Street and	d Number or Ru	ıral Route Number.
Ö	rs efter rs efter Dir	Cer		50.10.1.1g, 616. (656				0.1, 0.70	, 51410,		
	To the Hospital or Attending the Hours effer death To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 ★ Certifying Phy (Check only one)	sician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, death ination and/or in-	n occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	within 2 To the	₩	29b. Signature and title of certifier	اتحد		29c. Licens				signed (Monti	h, Day, Year)
			•	10		D00	54561	6	61	5106	
R.	(6)		30. Name and address of person who co	ompleted cause of death (II	tem 23a) (Type,	Print)	1 00	42)-22	-	^	4na.200
	Sta	te.	Schille Bhog. 31. Date filed (Month, Day, Year)	22. Registrar's Sig	mature _	John y	cold, the	cert+10,	Jaw	DOM.	104486
	Registi		JUN 0 8 2006	22. Registrar's Sig	Apan	le le					

DHMH 17 Rev 1/2001

		•	State of Maryland / Department of Health a 1- State Registrar Certificate of Death	and Menta	al Hygien Reg. N	7000	19742
			Decedent's Name (First, Middle, Last)		te of Death		3. Time of Death
Phys	sicia edica		Jack Arzoomanian	Jur	_	2006	10:05P M
Exar			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death	4	c. County of Death	
			Southern Maryland Hospital Center Clinton			rince Geo	rge's
Funer	_		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 2 TXIM 2 F 7 Yrs.	Min. (M	te of Birth onth, Day, Yea		place (State or Foreign intry)
Direct	or	-	578-30-8255 76 Usual Residence of Decedent	Jur	ne 21,1	929 New	York
/land			10a. State 10b. County 10c. City, Town or Location			-	10d. Inside City Limits
Man		Ď.	Maryland Prince George's Camp Springs				1 ☐ Yes 21 No
th the		E E	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Cou	intry?
23a 23a	1	2	6006 Joyce Drive 20748			USA	
or dec		Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Original Status If Yes, specify Cuban, Mexican,	gin? (Specify Yon, Puerto Rican,	es or No- etc.)	14. Race - Amer Black, White	
.UUSB hours after deeth with the Maryland turel', or Iteme 23a or 28a-1 ehow al Examiner must be taylified at	1	Dy	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No HYes, Give 1950 — 1 ☐ Yes 2 ☑ No Specify:			Specity:	_
5-0036 72 hours af naturel; or			1952		16b.	Kind of Business/li	ite
-CT2 hin 72 ni nat		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	t of working			
d 2127 filed within Hygiene. other than		E	3 Chief Accountant			fice of S of Defens	
		Re	17. Father's Name (First, Middle, Last) 18. Mother	er's Name (First,	, Middle, Maide	en Sumame)	
Aarylan 2 should be 1 and Mentel 16 marked c		2		andra	Kazar		
Maryland d 2 should be file th and Mentel Hy 17 le marked oth treumatic even?	4		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	er or Rural Rout	e Number, City	or Town, State, Zi	p Code)
C, I end Heelth			Doreen D. Arzoomanian Wife 6006 Joyce Drive C 20a. Method of Disposition (Name of	Camp Spr	ings,M	aryland Location - City or T	20748
ages int of t: If h	Q		1 ⊠Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln				
altimore, mit. Pages 1 er pertment of Hee portant: If item y injury or othe		İ	Cemetery J	Tune 9.2	2006_Br	entwood,	laryland
Baltimore, Marylan permit. Pages 1 and 2 should be Department of Heelth and Mentel Important: If them 27 te marked 1 any Injury or puther treumsite as	a		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collii 500 University B	ins Fune	ral Ho	me, Inc.	MD 20001
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	cardiac or respi	ratory arrest,	opi mg,	Approximate Interval Between
Physicia	an		Immediate Cause (Final disease or condition	the	are.		Onset and Death
/Medic			resulting in death) Due to (or as a consequence of):		/		
Examin		_	Sequentially list conditions, b	1/27			
pe,		ine in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,			
xecul and		Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
38760, icate be executed physicien and s the burial-transit		edical	d				
BOX 68 leath certifics attending pl		an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Date of deliv	
I Records, P.O. BOX (The law requires that the death certif ate has been signed by the attending page 2 should be deteched for use an		Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown in the past 12 months? 4 Pregnant at time of death 5 Other (specify)			Month	Day Year
P.C hat the d by t			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	25	Pa Did tabasas		
dS, P lires that signed t d be det		5	Partition of the significant conditions contributing to death but not resulting in the uniquenying cause given in Parti.		1 ☐ Yes		the cause of death? bably 4 🛣 Unknown
Records, he law requires t e has been signe		Completed	Nieles al start				
Re(he fay		E C	The things of the same of the		Ia. Was an autopsy performed?	prior to or death?	opsy findings available ompletion of cause of
In: Ti			25. Ya se referred to medical 26. Place	<u></u>	JYes 21√2N		2□ No
Of Vital Rec Physicien: The lav this certificate has ral director, page 2		To Be	examiner?	of Death (Chec		6 ☐Other (Speci	6.1
DOP Ng Ph terth			27. Manner of Death 1. ☐ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury at Work?	1	escribe how in		
ISIOI ttendir death. ctor: Af		atic	2 Accident investigation M 1 Yes 2 N	No			
Division of Vital or Attending Physicien: * efter death. Director: After this certifica in by the funeral director, p		Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Lo	cation (Street a ty or Town, Sta	and Number or Run ite)	al Route Number,
Division of Vital Hospitel or Attending Physicien: 24 hours effer death. Funeral Director: After this certifics lely filled in by the funeral director;			29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and	d place, and du	- to the co		
To the Hospitel within 24 hours (To the Funeral completely filled		Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat and manner stated.	th occurred at the	ne time, date a	nd place, and due t	to the cause(s)
To the Hospitel within 24 hours e To the Funeral t completely filled		ž	29b. Signature and title of certifier 29c. License number		29d. D	ate signed (Month,	Day, Year)
(ot1			Were 1 4200 Mill 00225	57	le	2-6	2006
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	P130	a Ta	1297	R
	CL		31. Date filed (Month, Day, Year) 32 Registrar's Signature	201.	m	2 20	735
	Stat istra		JUN 8 2006				

		1	State of Maryland / Department of Health 1- State Registrar Certificate of Death	and Mental Hy	/giene Reg. No. 2006	19743
	- I		Decedent's Name (First, Middle, Last)	2. Date of D Month	Day Year	3. Time of Death
1	Physicia /Medic	al .	Viola Fisher Ahalt	June	5, 2006 Year	8 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 13 E. 13th St. Freder		4c. County of Dea Frede	
		# -	5 Social Security Number 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		1	thplace (State or Foreign
	Funeral Director	- 1	215-18-1903 1 M 2 XF 82 Yrs. Months Days Hours	s Min. Sept	irth (1926) 19. Bir (1926) 19. Bir (1926)	3 MD
	ס		Usual Residence of Decedent 10a State 10b County 10c City, Town or Location			10d. Inside City Limits
	ehow	5	MD Frederick 100. County 100. City, Town or Location Frederick			1 Yes 2 □ No
	28a-f	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	within 72 hours after death with the Maryland ene. Than "natural", or tems 23a or 28a-f ehow te Medical Examinar must ke notified at		13 E. 13th St. 21701	1	USA	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C Armed Forces? 15. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or Nocan, Puerto Rican, etc.)	lo- 14. Race - Amo Black, Whi	
98	or Ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No If Yes Give 1 ☐ Yes 2 ▼ No Specification			hite
21215-0036	hours tural		3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	/Industry
7.	nin 72 n "na	plet	(Specify only highest grade completed) (Give kind of work done during me	nost of working		
212	filed with Hygiene. Ither ther	Completed	12 homemaker		own hom	e
nd	od ta be	Be	17. 1 Ethol o Field (Fine)	other's Name (First, Middi ary J. Car		
Maryland		70	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street</i> and <i>Num</i>			Zip Code)
Ma	2 6 9 10		Gay I. Ahalt (Daughter) 13 E. 13th St.			769
ē,	ges 1 and 2 t of Health if Item 27 or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City of	Town, State
E	Z thank	l	15 Burial 2 Cremation 3 Removal from State 4 Donation 4 Other (Specify)	6/8/06	Middleto	wn, MD
Baltimore,	permit. Pag Department Important: any injury o		21. Signal fire of Funesal Service Licens-se Donal To 31 E. main	hompson Fu St., Middl	ıneral Hom Letown, MD	e 21769
	Eil		23a Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock or heart ailure. List only one cause on each line.	as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Julyo	79	2 100
98	Examiner					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Lifet of Johnson Queen Course, (Disease or injury)			
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
760,	eath certificete be executed attending physicien and for use as the burial-transit	calE				
687	ficete p phys		d.	_	The state of the s	
Вох	n certi	M/u	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de	
	The law requires that the death certifices ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Month -	Day Year
P.O.	that the de ed by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 23e. Dio	tobacco use contribute	to the cause of death?
ds,	signed I	Completed by	h/0 /5-c=36 C7		Yes 2 No 3 F	robably 4 Unknown
Sor	w require been signal	ete		24a. W	as an 24b. Were a	utopsy findings available
Records,	sicien: The law certificate has b lirector, page 2 s	dwo		pe	topsy prior to formed? death? 2 ☑ No 1 ☐ Ye	
ita	ien: T	O		lace of Death Check only		
>	Physicien: rthis certificanal director,	To B	examiner? 1 Yes 20 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Other 4	Nursing Home 52Re		ecify)
0 0	ing Pl		27. Manner of Death 1 Phatural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury at Work? 1 Note of Injury 4 Work?		e how injury occurred	
Division of Vital	Attending r death. ector: After by the fune	cat	3 Suicide 6 Could not be 28a Place of Injury. At home farm street factors office		(Street and Number or F	Rural Route Number,
Di∨	after after Direct	Certification;	4 Homicide determined building, stc. (Specify)	City or 7	own, State)	
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 12*Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated.	e and place, and due to the death occurred at the time	ne cause(s) and manner a e, date and place, and du	is stated. ie to the cause(s)
	Vithin Fo the Somple	Me	29b, Signatura and title of certifiar 29c. License number		29d. Date signed (Mor	
	,		513 Mmg D146	25	June	7,2006
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	25 55 50	Fredra	1786
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 8 2006 32 legistrar's Signature			

			1 - For State Registrar	S	tate of	Marylar		artment of F		d Mental	Hygie Reg.		06	197	44
	Physicia		Decedent's Name (First, Mid JUDITH		OWN					2. Date Mont		Day 20	Year	3. Time of D	
	/Medic Examin		4a. Facility Name (If not institut UNIVERSITY S				TAL	4b. City, Town, o		-		4c. County			
	Funeral Director		5. Social Security Number 579-58-5702	6. Sex 1 ☐ M		7. Age (In yrs.	last birthday	If Under 1 Year Months Days	If Under 24 H	lin. 8. Date (Mont	of Birth	^{9ar)} 1946	9. Birthi	place (State or f	Foreign
	nyland how		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. C	ity, Town or L	ocation					1	10d. Inside City	
	Be-fs	Director	D.C.			W	ASHIN	GTON						14 Yes 2	2 □ No
	ter death with the Marylan Items 23e or 28e-f show ref must be rediffed	ai Dire	10e. Street and Number 2900 14th	St.,	N.W.	#614		10f. Zip Code 20011				Citizen of W		,	
5-0036	n 72 hours after death with the Maryland "neturel", or items 23e or 28e-f show edical Evanties must be rediffed at	by Funerai	11. Marital Status 1 □ Never Married 2 △ M 3 □ Widowed 4 □ Divorc	arried 1	Vas Dece Armed For Yes f Yes, Give Year or Da	θ	J.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes lierto Rican, et	or No-		k, White,	can Indian, etc. ACK	
0-61212	within 72 ene. then "nel	Completed	15. Deced (Specify only high Elementary/Secondary (0-12			4or 5+)	life.	edent's Usual Occup e kind of work done o DO NOT use retired	1)			RIVAT		dustry	
פר	be filed tal Hygi d other event, t	Be C	17. Father's Name (First, Middle	e, Last)					18. Mother's i	Name (First, M					
ylaı	should b nd Ments marked	ToE	DAVID JUDD						RUTH						
Maryland	2 a m 10		19a. Informant's Name/Relatio		•			ing Address (Street						201	019
	s 1 and f Health item 27 other ti		ARTHUR BROWN 20a. Method of Disposition	N/ HUS	BAN	20b.	Place of Disp	BENNING		RD. S		3#) : Location - G		SH. D	.c.
altimore,	Page ient o nt: If ry or		1 ☐ Burial 2X Crematio 4 ☐ Donation 5 ☐ Other		val from S			matory or other place KE CREM		6-12-	06	BELTS	VIL	LE, MD)
Balt	permit. Departmitimporte any niju		21. Signature of Funeral Service	e Licensee	Car	n=la		2. Name and Addres		AVE.,	N.E			MORTU D.C.2	
î			23a. Part 1. Enter the disease, shock, or heart failure. L	o mplications of your care	ons that ca	used the dea	ith. Do not en	ter the mode of dyin	g, such as card	liac or respirat	ory arrest,			Approximate Interval Betwe	
J.B	Fnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	a		Card		amythem	ilas					Onset and De	
	Examiner				Due to (d	or as a consec Multip		-lerons					1	5 4.3	
j.	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	1 "	Due to (d	or as a consec	quence of):		1.						
Ď,	ificate be executed g physician and as the burial-transit	i Examiner	that initiated events resulting in death) Last	c	Due to (d	or as a consec		enhalopa	thy			• • • • • • • • • • • • • • • • • • • •	- '	1.5 yrs	
09/89		edicai		d											
O. Box	The law requires that the death certif Ite has been signed by the attending tage 2 should be detached for use a.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		I ☐Live bi	come of pregn rth 2 Feta ant at time of c wn	al death 3	Ectopic pregnancy Other (specify)				23d. Date Mon		ery Day Yea	ar
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant cond						en in Part I.					he cause of dea	
Vital Records,	e lav has je 2	ompieted	Receivent Dioheter me	pheuma	nia	and	urina	my tract	in feon		Was an autopsy performed	pr ? de	rior to co eath?	psy findings avaingletion of caus	ailable se of
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	ding Ph th: After th funeral	tion	27. Manner of Death 1 Datural 5 Peni 2 Accident inves	ling stigation	(Month	f Injury n, Day Year)	28b. Time o	Worl	/ at k? Yes 2 □ No	28d. Desc	ribe how i	njury occurre	d		
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	Hospite 24 hours Funere etely fille	edical C	29a. Certifier 1 Certify (Check only one) 1 Medic	ai Examiner:	n: To the l On the ba and mann	sis of examina	owledge, deal ation and/or in	h occurred at the tim exestigation, in my of	ne, date and pla pinion, death o	ace, and due to courred at the t	the cause ime, date	e(s) and man and place, ar	ner as st	ated. the cause(s)	
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K	-12)		30. Name and address of person					Print) BALTIM	CRE	mnx	1226	3			
	Sta Registr	_	31. Date filed (Month, Day, Yes		AND DESCRIPTION OF THE PERSON NAMED IN										

06-03781 Walter Bailey

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

2006 19745

		1- For State Registrar					Certific	ate of	Death					Reg. No	N-up lug		1 1 1
Physicia dical Exami																	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		Matilda		ley.	/Wife		2	300 S	Steube	en A	venue	e, F	ort Wa	ashin	gton,	MD	20744
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Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra		21. Signature of Fi	uneral Service	Licens	see	/											vices, P.A
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Ann Brown Mary June 5, 2006 5:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 578–48–1364 8. Date of Birth (Month, Day, Year) April 8, 1934 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 KF Months Hours Hattiesburg, MS Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other then "natural", or items 23s or 28s-f show ont, the Madical Examinar rount by notified at Montgomery Bethesda MD XX Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 靣 6719 Wilson Lane 20817 United States Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black If Yes, Give Year or Dates: ۾ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Podiatrist Assitant 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mentai Pages 1 and 2 should be Milton L. Barnes, Sr. Cleo Whitening 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alicia Brown (daughter) 6719 Wilson Lane Bethesda, MD 20817 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H important: If its eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 6/12/2006 Brentwood, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Lipenses 3401 Bladensburg Road Brentwood, MD 20722 homps -1 Luchard 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis 4-6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine settending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown encephalopathy, end-stage renal failure, diabetes, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pulmonary hypertension, COPD, cardiac arrhythmia certificate has 1 Yes 2 No 1 Yes XXNo ial or Attanding Physician: T. s efter death.
It Director: After this certificate of in by the funeral director, pa 25. Was case referred to medical examiner? Y 26. Place of Death (Check only one) examiner? X 1 ☐ Yes 2 ☐ No Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours en 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D 006047 6/6/2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric J. Park, M.D. 9901 Medical Center Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUN 0 8 2006 Registrar

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BROWN Hary

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 5,2006 Year **Physician** Eleanor Beever 2:20 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner National Lutheran Home ROCKVIIIE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | May 24, 1920 Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🛛 F 218-01-4834 86 Yrs Maryland Director Usual Residence of Decedent death with the Maryland 10a. State Md. 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal invalies maillied at Montgomery Rockville Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9701- Veirs Drive 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other treasment. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: White Specify Completed by 3X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Factory Worker Industrial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alonzo Schisler Eleanor Cocnavitch P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristina Hughes-Executor 9701- Veirs Dr., Rockville, Md. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Glen Haven Cemetery-6/9/2006-Glen Burnie, Md. ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Hysong Co., Inc.
6510-16th St., NW, Wash., DC
hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
on each line. 22. Name and Address of Facility W. M. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, ir co shock, or heart failure. List on one cause Immediate Cause (Final disease or condition resulting in death) **Physician** monta /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mente Examiner The law requires that the death certificate be executed macin and burial-tran Due to (or as a consequence of) attending physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ pe 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s has certificate 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D61696 ans) 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) Lythonan yang Sharon Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 0 7 2006

P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 2, 2006 **Physician** Verme11 Bacote 4:06 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. 8. Date of Birth Hours Min. Nov. 17, 1937 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 ☐ M 2 □ F Fair Bluff, NC 239-60-7747 68 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "naturel", or items 23s or 28e-f ehow the Medical Examiner must be notified at Director Prince George's 1 Yes 2 □ No Maryland Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5767 Gladstone Way 20743 filed within 72 hours after death Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White alcan 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 vivorced American Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) I2 years College (1-4or 5+) Nurse's Aide Self Employed othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit thent of Heelth and Mental H tant: if Item 27 is marked oth jury or other treumatic even Henry Williams Cleo Gore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Bacote - Daughter 5767 Gladstone Way Capital Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Department of Important: if eny injury or once. June 7, 2006 4 Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as/a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine inding physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed emi 0 Box 68760. Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the attend 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation s effer des. Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospital within 24 hours e Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a Certifier completely and manner stated. 29b. Signature and title of certifier 29d. Date, signed (Month, Day, Year) 30. Name and address of per-Mn 31. Date filed (Month, Day, Year) State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12:25PM BROWN LINDA 2006 JUN 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOWARD GENERAL OLUMBIA COUNT HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 3/22/1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 1 F Months Days Hours 167-36-6758 63 Jamestown, N. Y Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a f show any injury or other traumatic event, the Medical Eventual tentual tentified at any injury of other traumatic event, the Medical Eventual tentual tentual tentual any injury of other traumatic event. MD Howard Columbia 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6105 Turnabout Lane 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give 2 No 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Instructor Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander M. Brown Mayme Burt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Brown/Brother 5426 Rt. Ripley, New York 14775 76 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/08706 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Beltsville, Md 5 Other (Specify) Chesapeake Crematory ⁴ 4 ☐ Donation peral Service Lic 22. Name and Address of Facility PHILIP D. RINA 21. Signatur of D.RINALDI FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on erich line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cho Je Priysician /Medical Due to (or a a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a copsequence of): Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 cai Physician/Medi 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an m autopsy performed disseminate 212 No 1 Yes ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Oth in 1 ☐ Yes 2 XNo Inpatient ۵ 2 ER/Outpatient 3 DOA 4 Nursing Horie 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural Injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

7350

31. Date filed (Month)

0

Day, Year)

368HS

lorg

June 04, 2006

hangen, MD,

MO

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			1 - For Stete Registrer	State of Marylar	nd / Depa <i>Cei</i>	artment rtificate	of H	ealth and Death		giene g Reg. No.	2006	19750
	*		1. Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		101	Lis 1	BOGF	IM			June	4,	2006	7:50PM
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, T	Town, or	Location of De	ath	4c. C	ounty of Death	
			Baltimore-Washingto	on Hospital		G1en	Bur	nie		An	ne Arun	de1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 24 H Hours Mi	8. Date of Bir	th v. Year)	9. Birthp	tace (State or Foreign
	Director		219-12-3135	M 2□F 82	Yrs.	10.0111.0	Days	1,00.0	n. (Month, Da 10/18/	1923	Mary	l'and
	P ,		Usuat Residence of Decedent	100 0	ty, Town or Lo							0d. Inside City Limits
	aryia	_	10a. State 10b. County								''	1XXYes 2 □ No
	8a-f	ctc	Maryland Anne Aru	ndel Cro	wnsvil							
	or 2	Director	10e. Street and Number			10f. Zip				-	on of What Coun	itry?
	23a		1373 St. Stephens			210				USA		
	de m	Funeral	Tr. Marian Grand	12. Was Decedent Ever in U Armed Forces?		Was Decede If Yes, speci	ent of Hi	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14	 Race - Americ Black, White, e 	
36	or i	by F	1 Never Married 2 Married 3 X Widowed 4 □ Divorced	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2	X No	Specify:		s	Specify: TT-	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Medical Exercises must be notified at	d b		Year or Dates:	1 40- D	danda Harra	1.0	Ai		10h Ki-	Whi	
전	n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual kind of won DO NOT us	k done a	uring most of w	rorking		Arunde	
7	withii she.	E	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		r/ Po				Coun		-
22	Hygin ther	Ö	17. Father's Name (First, Middle, Last)	<u>_</u>	Tarme	.17 10	1101		ame (First, Middle			
an	d d d	Be c	William Albert Bo	ohm Tr				Joseph	nine Mari	e Mas	ek	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ahow any injury or other traumatic avant, the Mudical Expiritive must be notified at ance.	ပ	19a. Informant's Name/Relationship (Typ		19h Mailir	na Address	(Street a		Rural Route Numb			Code)
Z	d2 s th an 7 ta		Joseph Boehm/ Son	50, 1 1411/	1	•						e, MD 21032
a)	1 and Healt em 2 ther		20a. Method of Disposition	20b. I	Place of Dispo	sition (Nam	ne of	1	Date		ation - City or To	
ွဲ	or o		XXBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crei H i 1 1	matory or ot crest		1			•	
┋	tant dury		4 Donation 5 Other (Specify)	Me	morial	Gard	ens	06,	/09/2006	Anna	polis,	MD
Baltimore,	Depa impo eny ir		21. Signature of Funeral Service Lieunes						bert E.			1 Home
	40.244		23a. Part1. Enter the disease, or complic						Road Bowi		20715	Approximate
,0928	Physician /Medical Examiner ithe pniai-transil	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a consecutive to (or a	quence of):	77	CCX	LEBILAC	INF	ALC		Onset and Death
9	± os se		IF FEMALE:	3c. If yes, outcome of pregn	ancv					200	M. Data of delice	1
.O. Box	that the death certifi ed by the ettending detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fete 4 Pregnant at time of c 9 Unknown	el death 3	⊒Ectopic pre ⊒ Other (spe				23	d. Date of delive Month	Day Year
<u>α</u>	requires that the reen signed by th hould be detache	F.	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	inderlying ca	ause give	n in Part I.	23e. Did 1	obacco use	e contribute to the	ne cause of death?
ds,	signe signe								10	Yes 2	No 3 Prob	ably id Unknown
Ö	~ D in	Completed							24a. Was	an	24h Wara auto	psy findings available
ĕ	has has	E							auto	psy prmed?/	prior to condeath?	mptetion of cause of
	n: The								1 ☐ Yes		1 🗆 Yes	2 NO
Vital Record	Physician: The this cartificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe		eath (Check only			
ō	Phys this al dii	٠ <u>.</u>	1 Yes 2 PNo 27. Manner of Death	Inpatient 2	28b. Time o		^	4 Mursing	Home 5 ☐ Resi			1)
5	fing Aftar funer	0	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	M	8c. Injury Work	ran Yes 2 ∐ No	20d. Describe	now injury	occurred	
Si	Attending in death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome form at			163 2 110	29f Location /	Stroot and	Number or Rura	J Payto Nimba
Division of	ital or A	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)				City or To	wn, State)		
	To the Hospitai or Attending Physician: within 24 hours after death. To the Funerai Director: Attar this carlific completely filled in by the funeral director.	edicai	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin	sicien: To the best of my known: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and pla pinion, death oc	ice, and due to the curred at the time,	cause(s) a date and p	nd manner as st lace, and due to	ated, the cause(s)
	To the To the Comp	2	29b. Signature and title of certifier	1		29c.	. License	nu <i>m</i> ber		29d. Date	signed (Month, I	Day, Year)
			1 PM	1-				0055	703	Jur	24.	2006
			30. Name and address of person who co	mpteted cause of death (Ite	m 23a) (Type,	Print)						
_			BATAMORE W.	ASMINGTON	MEDIC	str.	CER	URDZ	ains	URNI	C MI	7
	Sta Regist		31. Date filed (Month, Day,	7 2006 Registrate Sign	ature	do	دیان					

			1- State of Maryland / Depart State of Maryland / Depart State of Maryland / Depart Corti	tment of Health and M	ental Hyg	iene
T		4	Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h 3. Time of Death
	Physicia /Medic		Helen Smith Becker		June	5, 2006 10 A. M
	Examin	er	_ Edenton _	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birtholace (State or Foreign
Ð	Director		134-16-1646 12 M X-XT 78 Yrs.	Months Days Hours Min.	(Month, Day, Aug. 2	8, 1927 New York
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ition		10d. Inside City Limits
	a-f eh	ctor	MD Frederick Freder	ick		1 Y es 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show says injury or other traumatic event, the Medical Examinational be multified at DDGs.	Director	10e. Street and Number 5800 Genesis Lane #315	10f. Zip Code 21703	1	0g. Citizen of What Country?
	Jeath v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	as Decedent of Hispanic Origin? (Spe	ecity Yes or No-	USA 14. Race - American Indian,
ထ္	or Iter		Armed Forces? If Y 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	∕es, specify Cuban, Mexican, Puerto I ∃Yes X □ No <i>Specify:</i>	Rican, etc.)	Black, White, etc. Specify: T.Th. + -
8	hours lural',	d by	3 1 Widowed 4 □ Divorced Year or Dates:	nt's Usual Occupation		16b. Kind of Business/Industry
7	in 72 in "na	Completed	(Specify only highest grade completed) (Give kir	nd of work done during most of workii O NOT use retired)	ng	Tob. Italia of Sasillessaniaustry
212	filed with Hygiene other the	Com	4 h	omemaker		own home
Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, Last) Alfred Henry Smith	18. Mother's Name		
Ĭ	should nd Mer mark matic	ို		Address (Street and Number or Rura	ine Di	
	alth ar 27 to or trau		Barbara Bartlett (Daughter) 2817			
Baltimore,	of He of He of He or oth		To Missing 1 2 Cremation 3 Hemoval from State 1	tory or other place)		20c. Location - City or Town, State
ţ	t. Pag rtment rtent: rjury c		4 Donation 5 Other (Specify) Mt. Olive	et Cemetery6/9	/06 _	Frederick, MD
Ba	Depa Impo eny l	1	21 Synature Fineral Service Lickness 22. N	onald B. Thomp	son Fu	neral Home etown, MD 21769
	akë.		231. Part 1. Enter the disease or emplications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac o	r respiratory arr	etown, MD 21/69 Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	CIV		nset and Death
	/Medical Examiner		resulting in death) Due to (or as a sequence of):			1
	1984. I	ē	Sequentially list conditions, if any, leading to firm rediata cause. Enter Underlying			
	outed nd ransit	Examin	that initiated events c.			
,092	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
687	physics the b	dical	d			
Box (death certifica e attending ph od for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
.O. B	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	1 Yes 2 No	ctopic pregnancy Other (specify)		Month Day Year
<u>α</u>	that the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the undi-	erlying cause given in Part I.	23e. Did tot	pacco use contribute to the cause of death?
Vital Records,	The law requires that the ate has been signed by the bage 2 should be detache	d by	Employens			s 2 No 3 Probably 4 Unknown
000	s beer 2 shou	Completed	cerenous ruleus derian		24a. Was a	
æ		mo			autops perforr 1 Yes 2	ned? death?
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		
	Phys this ral din	. To	1 Yes 2 100 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)	3 DOA 4 Nursing Hor		once 6 Cother (Specify) ow injury occurred
ion	Attending Phy r death. ector: After thi by the funeral o	atlor	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division of	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	it, factory, office	28f. Location (St City or Town	reet and Number or Rural Route Number, n, State)
	Hospital or 24 hours afte Funeral Dir tely filled in I	ပ	29a. Certifier f Certifying Physician: To the best of my knowledge, death o	accurred at the time, date and place :	and due to the ca	nuse(s) and manner as stated
	n 24 h n 24 h ne Fur oletely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigated).	stigation, in my opinion, death occurre	ed at the time, d	ate and place, and due to the cause(s)
	To the I	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
			A AMMIN 1)	122161		Xunes 2606
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	D27101 teny au. Fr	don	Makon
	Sta Registi		31. Date filed (Month Day, Year) 32. egistrar's Signature	alles	S CW	· · · · · · · · · · · · · · · · · · ·
	. realist					

DHMH 17 Rev 1/2001

		1 - For State Registrar				nd / Depa		lealth and M	lental Hygi	Are Legible iene2 () () (og. No.	5 19752
Physicia /Medic		1. Decedent's Name Pegg							2. Date of Death Month June 7	, 2006 Yee	10:30P ^M
Examine		4a. Facility Name (If r	not institution, gi Nichola		n <i>ber)</i>		4b. City, Town, or Wald	Location of Death		4c. County of De	eath arles
Funeral Director		5. Social Security Nut 577-42-30	089	Sex 1 □ M 2X F	7. Age (In yrs. 7		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 3,	Year)	Birthplace (State or Foreign Country) rginia
show	'n		10b. County		10c. Ci	ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes X☐ No
death with the Maryland time 23s or 28s-1 show if must be notified at	Director	Maryland 10e. Street and Numl 1507	Charles ber Nichola			Waldor	10f. Zip Code	20601	10	0g. Citizen of What	Country?
Irs after	by Funerai	11. Marital Status 1 Never Marrier 3 Widowed 4	d 2 ☐ Married		2 ∕⊡ No 'e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 і No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	mencan Indian, hite, etc. White
vitnin 72 nou ne. hen "neture nivedicel E	Completed	(Specify Elementary/Second	15. Decedent's £ y o <i>nly highest gi</i> dary (0-12)		-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired nboard Op	during most of work f)	ing	16b. Kind of Busine	
d be filed wintal Hygie ed other to swant.	Be	10 17. Father's Name (F Earl Wood				SWITCH	ibourd op	18. Mother's Nam		faiden Surname)	uru 01 Eu.
trsumati	To	19a. Informant's Name Sandra K.	ne/Relationship	(Type, Print)	hter				al Route Number,	City or Town, State	a, Zip Coda)
Pages 1 ar nent of Hee nt: if itsm: iry or other		20a. Method of Dispo	osition Cremation 3 (☐Removal from	State 20b. I	Place of Dispo cemetery, crea	osition (Name of matory or other place		Date 2	Valdorf, I	
Departm Departm importa sny inju		21. Signature of Fun	eral Sery	oh	M000)53 22	2. Name and Addres		3035 0	ld Washin	ngton Road Ildorf, MD
nysician		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List only Final	nplications that c one cause on e	eused the deal	th. Do not ent	60	g, such as cardiac		ost,	Approximate Interval Between Onset and Death
/Medical Examiner	je.	Sequentially list conditions, to am,	ditions,	b	or as a consec						
be executed sician and burial-transit	Examiner	cause. Enter Undert Cause (Disease or in that initiated events resulting in death) La	lying hjury	c	or as a consec	quence of):					-
8 2 3	a			d							
The law requires that the death certificate is the has been signed by the attending physipage 2 should be detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	nonths?		inth 2 ☐ Feta ant at time of c	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
w requires that the dispersion of the should be detached	þ	Part II. Other signific	cant conditions	contributing to de	eath but not res	sulting in the u	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 Anknown
ician: The law re certificete has bee rector, page 2 sho	Completed								24a. Was ar autops perform 1 Yes 2	y prior t ned? death	autopsy findings available to completion of cause of ? es 2 \(\sum \text{No} \)
ysician is certifii director	o Be	25. Was case referred examiner?	ed to medical to	Hospital: 1 🗆 I	npatient 2] ER/Outpatier	nt 3 DOA Oth		h Check only one	nce 6 □Other (S	(pecify)
ding Ph	ation: 1	27. Manner of Deat 1— Patural 2 — ccident	5 Pending investigate	on		28b. Time o Injury	28c. Injur Wor	y at		w injury occurred	
To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	286. Place	of Injury - At h ng, etc. (Speci	nome, larm, str ify)	reet, factory, office		28f. Location (Str City or Town		Rural Route Number,
the Hosp tin 24 hou the Fune apletely fil	ledicai	(Check only 2 one)	2 Medical Exa	miner: On the ba	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ause(s) and manner ate and place, and d	fue to the cause(s)
Vitt CON CON	Ž	29b. Signature and to	ife	4	Mal	ti-	29c. Licens	ASI_	25	6/8/06	опіп, Day, Year)
85 Sta		30. Name and addre Dr. Krish 31. Date filed (Month	an Mathi	ır, 3500		ashingt		102, Wal	dorf, MD	20602	

State Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

JUN 0 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 4:15 P 06 06 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and num Bu None hoc 1 Year It Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days Months Hours 10XM 2□F Yrs. June 28, 1939 Michigan 66 363-36-1324 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 1 Yes 2 □ No Frederick Mount Airy Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21771 United States 1206 S. Main Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 Widowed 4 Divorced

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

908 Stubblefield Lane

Engineer

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

rthen "naturel", or iteme 23s or 28s-f ehov the Medical Examinar must be notified at

filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Directo

Funeral

Completed by

permit. Pages 1 end 2 should be filed within. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "n eny injury or other treumatic event, the Meal once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 9, 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Pine Grove Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuceral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) CERTIFIC by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed hes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 es 2 No Other: Hospital: 1 Latient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injur 28b. Time of After Natural 5 Pending 2 No efter death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office filled in by (Specify) 4 Homicide building, etc Buildin within 24 hours e To the Funeral L To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of erson who completed cause of death (Item 23a) (Type, Print) SONTE GREEN ST RO South egistrar's Signatur State 9 2006 Registrar

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Elementary/Secondary (0-12)

Jav Boyer

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

Linda R. Boyer / Wife

28d. Describe how injury occurred

Location (Street and Number or Rural Route Homber City or Town, State)

16b. Kind of Business/Industry

Electrical

20c. Location - City or Town, State

Mt. Airy, Maryland

Mt. Airy, Maryland 21771

Approximate Interval Between Onset and Death

Year

Baltimore, Maryland 21202

MEDICAL EXAMINER

23d. Date of delivery

Dav

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

23e. Did tobacco use contribute to the cause of death?

2 NO

APPROVED BY

1 🗌 Yes

21 No

24a. Was an

1 ☐ Yes

18 Mother's Name (First, Middle, Maiden Surname)

Catherine McMorrow

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

2006

4985

			For State Registrar	State of Ma	ryland / [nt of H	ealth a	ind Mer	ntal Hyg	Reg. No.	2006	197	154
	Dhusisi	.00	1. Decedent's Name (First, Middle, Las	t)					2.	Date of Dea Month	ith Day	Year	3. Time of	
	Physici /Medic	_	Florence A		lle					ine	12	2006	11:45	РМ
1.	Examin	er	4a. Facility Name (If not institution, give					Location of	f Death			County of Dea		
		36-2	Montgomery General 5. Social Security Number 6. Se	l Hospitai	(In yrs. last bir		Olney ler 1 Year	If Under 2	24 Hrs. g	Date of Birtl		ntgome	ny rthplace (State o	of Foreign
- 20	Funeral Director			□M 2√2 F		Yrs. Month		Hours	Min. So	Date of Birtl (Month, Day Dtember	7, Year)	C	ountry) ryland	
90.	ס		Usual Residence of Decedent							7.00378000		, 2, , , , ,		
	show	_	10a. State 10b. County Maryland Montgo.	ma 4.1	10c. City, Tow	n or Location							10d. Inside Ci	
	8a-f	scto	9	nery	πουκ		7: 0:1:				10- 011			
	with ti	Dir	10e. Street and Number				Zip Cod <i>e</i> 20853:	22/8			-	zen of What C	es of Ar	maniac
	eath mag	Funeral Director	14214 Arctic Aver	12. Was Decedent E	ver in U.S.				in? (Specify			14. Race - Am		- Cucu
(0	r Itan	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2√ N		13. Was Dec			, Puerto Ric	an, etc.)		Black, Whi	te, etc.	
93	rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 L Yes	22 No	Specify:				Specify: C	aucasia	2
21215-0036	within 72 hours after death with the Maryland one. then "naturel", or itama 23a or 28a-f show the Madical Evanti wr must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a	Decedent's Us (Give kind of v	vork done d	durina most	of working		16b. Kir	nd of Business	/Industry	
121	hen.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)	`life.` DO NOT		•				11		
2	Hygie Hygie ther t		11 HS Grad 17. Father's Name (First, Middle, Last)	4		nom	emake		r's Name (F	irst, Middle,		HOME		
an	d be ental	To Be	Milton Wate	na Beamen				,	Ruth 1	ucas				
Maryland	shoul nd M	F	19a. Informant's Name/Relationship (7		196	. Mailing Addre	ss (Street a				r, City o	Town, State,	Zip Code)	
ž	alth a alth a 27 is		Robert H. Brunel	le Husbo	and 1	4214 Ar	ctic	Avenu	e, Roc	ckvill	e, M	larylan	d 2085.	3-224
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or itama 23a or 28a-f show apprintly or other traumatic event, the Madical Exact at must be inclifted at ance.		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place o cemete	f Disposition (N	iame of r other plac	e)	Date	- 1	20c. Lo	cation - City or	r Town, State	
Ĕ	Page ment ant: i		4 Donation 5 Other (Specify)	St. P.	aul's C	emete	ry 6.	/19/20	006	Hill	shoro,	Maryla	rd
Salt	Departi Departi Importi eny inj		21. Signature of Funeral Service Licen	9 /h		22. Name	and Addres	ss of Facility	y omo 7	D A				
ш	E = 0 2	. 117	23a. Part1. Enter the disease, or com	111000		12 So	uth S.	econd	Stree	et, De	nton	, Mary	land 21	529
			shock, or heart failure. List only	one cause on each lin	the death. Do	not enter the m	ode of dylni	g, such as o	cardiac or re	spiratory ar	rest,		Approximat Interval Bet Onset and I	ween
ji.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	t Cance	-							1 year	r
	Examiner			Due to (or as	a consequence	of):								
8		er	Sequentially list conditions, if any, trading to initioadate cause. Enter Underlying	b. Due to (or as	a cor sequence	Of):								
	uted d ansit	Examiner	that initiated events	c –										
oʻ	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as	a consequence	of):								
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x 68	The law requires that the death certificate in the has been signed by the attending physicage 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				- 300		Ι,			1
Вох	aath c attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐Ectopic 5 ☐ Other					2	3d. Date of de Month		Y <i>e</i> ar
P.O.	the de	iysid	1 □ Yes 2 □ X No 9 □ Unknown	9□ Unknown	timo or dodan	o 🖂 O KII OI (specify							
	res that Igned b be deta	by Pt	Part II. Other significant conditions of	ontributing to death be	ut not resulting i	n the underlying	g cause give	en in Part I.		23 <i>e</i> . Did to	bacco u	se contribut <i>e</i> t	to the cause of d	leath?
rds	w require: been sig should bi	ed b	Hypertension, o	lysphasia						1 □ Y	'es 2[Myo 3□P	robably 4 🗆	Jnknown
Vital Records,	aw re is bee 2 sho	Completed	N.1						Ī	24a. Was autop			utopsy findings completion of c	
Ä		E O								perfor	rmed?	death?	s 2□ NdN//	
ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						of Death (C	heck only o	ne)			
of V	thys this	မ	1 ☐ Yes 2 ☐ No	Hospital: 1 ☑ Inpatie		utpatient 3 🗆	1	4 🗆 1401				3 □Other (Spe	ecify)	
n c	ing P	on:	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injui (Month, Da)		Time of Injury	28c. Injun Worl	k?		. Describe h	iow injun	y occurred		
isio	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be		iny - At home for	M erm street fact		Yes 2□N		Location (S	Street and	d Number or F	Rural Route Num	her
Division	ii or Attending Patter death. I Director: After I d in by the funera	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	am, street, lact	ory, onice		201.	City or Tow			10.21 110410 14011	561,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledg	e, death occurre	ed at the tim	ne, date and	d place, and	due to the	cause(s)	and manner a	s stated.	
	ne Ho 24 t ne Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and examination are stated.	nd/or investigati	on, in my o	pinion, deat	th occurred	at the time, o	date and	place, and du	e to the cause(s	1)
	To the within To the comp	Σ	29b. Signature and title of certifier				29c. Licenso	e numb <i>e</i> r				-	th, Day, Year)	
			Dr. Letric V	error - The in	citore		Doon	8542			3026	= 13,	2006	
			30. Name and address of person who					1						2002
	to an analysis	331	Libuse Heinz-Mon	22 Books	ar'e Signatura	-		Hven.,	, #2/5	, whe	aton	, Mary	eand 20	1902
*	Sta Registi		31. Date filed (Month, Day, Year)	2006	ers signature	Charles	18 1							
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-2		3		4	All ballings							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** RUTH JUNE 2006 5:30P ANN COX /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HIGHWAY. NEWBURG

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 11050 CRAIN APT #14 CHARLES 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2/CDE 65 Director OCT.18,1940 MARYLAND 215-38-5338 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
shir: If Items 72 is marked other then "natural", or Itams 23s or 28s-1 show they or other traumatic event, its Markes Explication or the profiles at my or other traumatic event, its Markes Explications. 1 ☐ Yes 2√No Director MARYLAND CHARLES NEWBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HIGHWAY, APT. 11050 CRAIN 20664 U.S.A. #14 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☒ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OFFICE MANAGER DOCTOR'S OFFICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 HAROLD F. COX DOROTHY M. BAILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 Is any injury or other traing once. SHELBY TIPTON-DAUGHTER 7755 TIPTON PLACE, PORT TOBACCO, MARYLAND 2067 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITIAN CREMATORY 6-15-06 | ALEXANDRIA, VIRGINIA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 node of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARUTNOMA Physician 8 Krono MX /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physicien Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown peudis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2□ No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 Tyes 2 No Be 26. Place of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Specified 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel within 24 hours To the Funerel 29a. Certifier Ecertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ro the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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State Registrar

ress of

31. Date filed (Month, Day, Year)

ORIGINAL

erson who completed cause of death (Item 23a)

2006

477

32. Registrar's Signature

(Type, Print

			1 - For Stete Registrer	State of Ma	-		ent of F		Mental H	ygiene Reg. No.	ZUUb	19757
П	×		1. Decedent's Name (First, Middle, Las	')					2. Date of D	eath Day	/ Year	3. Time of Death
	Physici /Medio		NATIVIDAD C	ANALES					May	25	2006	21:15 ^M
4	Examin		4a. Facility Name (If not institution, give	street and number)		4b. (City, Town, or	r Location of Dea		4c.	County of Death	F
			HOLY CROSS				LVER S				ONTGOMERY	
	Funeral		5. Social Security Number 6. Se	x 7. Age	e (In yrs. last birth	rs. Mon	ths Days	If Under 24 Hrs Hours Min	. (Month, L	Day, Year)	Cour	* *
Ь	Director		216-19-1819 Usual Residence of Decedent		76				$\perp 12/25$	1929	9 EL SA	ALVADOR
	yland		10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
	Mar a-f-e	io	MD MONTGOME	RY	SILVER	SPRI	NG					1 Yes 2 No
	th the	Director	10e. Street and Number			10f	. Zip Code	··· ·		10g. Citi	zen of What Cour	ntry?
	23a	al	6 CARTER GROVE CT	•			20908			EL S	SALVADOR	
36	within 72 hours after deeth with the Maryland jiene. r than "natural", or Items 23a or 28a-f ehow the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▲ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1Yes 2 M If Yes, Give Year or Dates:		If Yes,	ecedent of H specify Cuba s 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)		14. Race - Americ Black, White, Specify:	etc.
Maryland 21215-0036	2 hou	ted	15. Decedent's Ed		16a. C	Decedent's	Usual Occup	ation	SALVADO		nd of Business/ind	PANIC
215	nin 72 In "In Medi	Completed	(Specify only highest grad Elementary/Secondary (0·12)	le completed) College (1-4or 5		'Give kind o life. DO NC	f work done i T use retired	during most of wo d)	rking			,
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b	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middl			,
yla		ပ	UNKNOW						A CANAL			
lar		. 5	19a. Informant's Name/Relationship (T								r Town, State, Zip	
	2 = N L		REINA I.HENRIQUEZ	(daug				HALLOW D		,	VA.2015	
Ore	5 5 T C		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Cometery,	crematory	Name or or other plac	´ I	Date		cation - City or To	
Baltimore,	t. Pa timen tant: ijury		4 □ Donation 5 □ Other (Specify		jardin			o 6/1	1/2006	LA U	JNION, EL	SALVADOR
Bal	permit. Pag Department Important: I any Injury c		21. Ignature o Funeral Seguige Vicen	3 400	() ()						RVICIOS I DC 2001	FUNERARIOS .1
	Physician	i 1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lication's that caused ne cause on each lir ACUTE	ne.	ot enter the	mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		a consequence of		JC.					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	a consequence of		NG .					
	ate be executed physicien and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of	1.						
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687	flicate g phy: as the	edic		0.								
O. Box	at the death certificate be executed by the ettending physicien and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectop 5 □ Other	ic pregnancy (specify)			4	23d. Date of delive Month	ory Day Year
<u>م</u>	that the od by detac		Part II. Other significant conditions co	ntributing to death be	ut not resulting in t	the underlyi	ng cause give	en in Part I.	23e. Did	tobacco u	se contribute to th	ne cause of death?
rds,	law requires that the as been signed by th 2 should be detache	ed by							10	Yes 2	BNo 3□ Prob	ably 4 Unknown
of Vital Record	law requas been 2 shoul	Completed							24a. Wa		24b. Were auto	psy findings available
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ita	sian: artifica ctor. I	Be	25. Was case referred to medical examiner?					26. Place of De	ath (Check only			
<u>></u>	Physician: this certific ral director,	P	1 ☐ Yes 2 🗹 No	lospital: 1 Inpatie		oatient 3	DOA Oth	er: 4 🗆 Nursing l	Home 5 ☐ Res	sidence 6	6 □Other (Specify	1)
			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 28b. Tir	ury	28c. Injun Worl	y at k?	28d. Describe	how injur	y occurred	
sio	r Attending er death. rector: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ No				
Division	무를들	Certification;	4 Homicide determined	28e. Place of Inju building, etc	ury · At home, farn c. <i>(Specify)</i>	n, street, fa	ctory, office		28f. Location City or To	(Street and own, State,	d Number or Rura)	l Route Number,
	To the Hospitel of within 24 hours a To the Funeral Completely filled in	edical (29a. Certifier 1 Certifying Phyone) 2 Medical Exem	sician: To the best of inar: On the basis of and manner sta	examination and/	death occur or investiga	red at the tin tion, in my o	ne, date and place pinion, death occi	a, and due to the urred at the time	e cause(s) , date and	and manner as st place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		110		29c. License	e number		29d. Date	e signed (Month, I	Dey, Year)
) //L	2 , /	イル		D633	43		5/26	/06	
)	(2)		30. Name and address of person who c									
	(2)		IRINA RUBAN MD.		REST GLEN		, SIL	VER SPRI	NG, MD	20910		
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 8 2006	32. Registra	ar's Signature	de						

		_	1 - For State Registrar		Marylan		artment rtificate			and M		Reg. No.	106	1975	8
	Physici	an	1. Decedent's Name (First, Middle		T						2. Date of Dea Month	Day	Year 106	3. Time of Death 8:30 P. M	ţ
10000	/Medic Examin	-	Bernard Lewis 4a. Facility Name (If not institution				4b. City, 1	Fown, or	Location of	of Death	June		ty of Death		_
	Lxaiiiii		Prince George'	s Hospital	Cente	r	C	heve	rly			Princ	e Geo	orge's	
	FuneralDirector		5. Social Security Number 217–36–9304	6. Sex 7 1 X 3 M 2 ☐ F	. Age (In yrs.	last birthday) Yts.	Il Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt 3/1/42	h y, Yea <i>r)</i>	Cou	place (State or Foreign intry) D.C.	7
	and w.c.		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
	Mary 	호	Md.	P.G.		Lanh	.am							MXYes 2 □ No)
	h the	<u>le</u> c	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	intry?	_
	23a c	alD	9940 Park Str	eet					207			U.S.			
980	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or itame 23e or 28e-f ehow or other traumatic event, it a Musical Evarian must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deced Armed Ford ed 1 2 Yes 2 If Yes, Give Year or Dat	es? !□No ! 60_!	· ·	Was Deced f Yes, spec	_	spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)	Speci	ack, White <i>ify:</i> Af	ican Indian, , etc. rican— nerican	
Maryland 21215-0036	within 72 ho ene. than "natur i.e Mudical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th	's Education t grade completed) College (1-	4or 5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired)	tion uring mos	t of worki	ng	16b. Kind of I		Department	
d 2	e filed within al Hygiene. I other than '		12 LTI 17. Father's Name (First, Middle, I	Last)		LILE	ilian i		18. Mothe	ır's Name	(First, Middle,			Depar dilerre	_
ylan	should be and Mental marked o	To Be	Bernard L.		Sr.					ce Br					
Mar	alth and 2 sh		19a. Informant's Name/Relations Hazel Campbell				Park				Md. 20	or, City or Town	n, State, Zi	p Code)	
nore,	ages 1 ant of He tr. if Item y or other		20a. Method of Disposition 1★ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		tate	Place of Disponentation of Disponent Contract Co	natory or ot	ther place		ء 5/9/0	ate	20c. Location	-		
Baltimore,	permit. Pages Department of H Important: if Its eny injury or of		21. Signature of Funeral Service		rail						ons Co.				
*	.e. 8		23a. Part1. Enter the disease, or	complications that ca	used the deat	h. Do not ent	925 B er the mode	urro e ol dying	ugns I, such as	AVE.	r respiratory ar	wasn.,D	.C.	20019 Approximate	
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	- a Acu		MYOCA	ARDIZ	+1_	NA	-ARC	TION			Interval Between Onset and Death	
8760,	te be executed ysicien and te burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a conseq										_
P.O. Box 6	death certific e attending p nd for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ∏Feta ntattime old	Ideath 3[Ectopic pre Other (spe						ate of deliving	ory Day Year	p. mode
	es tha	ρ	Part II. Other significant condition	ns contributing to dea	ath but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to			the cause of death?	1
Vital Records,	The ate h page	Completed									24a. Was autop perfo 1 Yes	rmed?	Were autoprior to codeath?	opsy findings available ompletion of cause of 2 No	,
Vita	Physician: 'this certifica	Be	25. Was case referred to medical examiner?	Hospital:				Othe	•		(Check only o				
	ding Phys h. After this funeral di	on: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pendin	28a. Date of		ER/Outpatier 28b. Time o Injury		Bc. Injury Work	4 🗀 190		ne 5 Resid			fy)	_
Division of	deat deat ctor: y the	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of	of Injury - At h	ome, farm, str	M reet, factory		′es 2 🔲	No :	281. Location (S City or Tox		iber or Rui	al Route Number,	
۵	To the Hospital or / within 24 hours after To the Funeral Direct completely filled in b		29a. Certifier 1 Certifyin	g Physician: To the t Examiner: On the bas	pest of my kno	wledge, deat	h occurred a	at the tim	e, date an	d place, a	and due to the	cause(s) and m	nanner as	stated.	-
	the Hi in 24 the Fu	Medical	one)	and manne	ar etated		-								
	To the within 2 To the comple	2	29b. Signature and title of certified	(71			29c	License	number	1 -	Y	29d. Date sign		*	
,			16 34	1 urasi			11.	DY	1801	42		6-	4-	06	_
_				who completed cause SAR FARAZ	of death (Iter	58/	Print)	LERI	KN	LANE	= £	OCKYILL	E, M	06 D 20852	w
Car Se	Sta Regist		31. Date liled (Month, Day, Year) JUN 0 7 2	who completed cause SAR FARAZ	gistrar's Signa	ature	le						/		

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. No. 006	19759
(2	Physician	1. Decedent's Name (First, Middle, Lest)		2. Dete of Death Month Dey Year	3. Time of Death
	Physician /Medical	Eldica Cadette	4b. City, Town, or Lo	5 26 06 cation of Death 4c. County of Death	4:05 Pm.
	Examiner			Prince G	
	Funoral	Clinton Nursing & Rehab C	lest birthday) If Under 1 Year If Under 24 Hrs.		nplace (State or Foreign untry)
	Funeral Director	579-70-2540 1 M 2 K 81	Yrs. Months Days Hours Min.		inidad
	wor.	10a. State 10b. County 10c. City	y, Town or Location		10d. Inside City Limits
	-fah	MD Prince Georges C1	linton		1 ☐ Yes 2X No
	itier death with the Mai r Herrs 23a or 28a-f si river must be notified Finneral Director	10e. Street and Number 9211 Stuart Lane	101. Zip Code 20735	10g. Citizen of Whet Cou USA	
9036			If Yes, specify Cuben, Mexican, Puerto	Specify: B1	a, etc. ack
5-0	72 hc	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/li	ndustry
Maryland 21215-0036	ss 1 and 2 should be filed within 72 hours a of Heelth and Mantel Hygiene. Item 27 is marked other than "natural", or other traumatic event, the Medical Exam. To Re Commisted by	Elementery/Secondary (0-12) College (1-4or 5+) 12th	Nursing Aid	Hospita1	
pu	tel Hygie d other avent, u	17. Fether's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Sumame)	
yla	should be to and Mentel I amerked of numeric even	David Thomas	Adde	UI Charles City or Town State 7	n-avail.
Mar	d2sh thend 7 is m traum	19a. Informant's Name/Reletionship (Type, Print) Heather Norris/daughter	19b. Mailing Address (Street and Number or Rure 2206 Savannah Stree	of Houte Number, City of Town, State, 2.	[®] 20020
	Heelth Heelth Iem 27 other tra	The state of the s	lace of Disposition (Name of emetery, crematory or other place)	Date 20c. Location - City or T	
Baltimore,	permit. Peges 'Depertment of Pimportant: if ite any injury or of once.	1 LX Buriat 2 Li Cremation 3 Li Hemoval from State		/1/06 Falls Chu	rch VA
altir	nit. P sertme sortan / Injur	21. Signature of Egneral Service Licensee	22. Name and Address of Fecility	420 H	StreetNE
ä	Depermination of the samp is	Tran / Dlouser 11	B K Henry Funera		DC 20002
		23a. Part I Enter the disease, or complice lons that caused the death shock, or heart failure. List only one cause on each light.	n. Do not enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between
	Physician /Medical	Lune dista Causa (Final			Onset and Death
ı	Examiner	disease or condition resulting in death) a. Multiple	e Myeloma or es e consequence of):		
			, 55 5 50.1004_51.10		
	rificate be executed ng physician and as the burial-trensit	Sequentially list conditions, if one leading to immediate	r es e consequence of):		
68760,	be exercian cician burial	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury c			
387	ntificate be ng physicia as the bur	that initieted events resulting in death) Last Due to (or	r as a consequence of):		
Box (certification and ing as a second	d			
	daath e ette	Part II. Other eignificant conditions contributing to death but not resu	ulting in the underlying cause given in Part 1.	23b. Did tobacco use contribute	to the cause of death?
P.0	law requires that the death certificate be executed as been signed by the ettending physician end is 2 should be detached for use as the burial-trensition in the second in the physician Madinal Examination.			1 ☐ Yes 2 🔀 No 3 ☐ Pro	obably 4 Unknown
	signed d be d			24a. Was an autopsy 24b. V	Were autopsy findings
Records,	The law require sata has been si, page 2 should			performed? a	available prior to completion of cause of death?
Rec	The law ata has page 2:			SOUTHWARD MANAGEMENT	I □ Yes 2 □ No
	in: Tr		26. Place of Death	h (Check only one)	22.10
of Vital	Physician: this certific ral director,	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2	Othor	me 5 Residence 6 Other (Spec	cify)
	ng Phy fter thi uneral	27. Menner of Deeth 28e. Date of Injury (Month, Day Year)	Injury Work?	28d. Describe how injury occurred	
sio	Attending or deeth. Cotor: After fune by the fune	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f. Location (Street and Number or Ru	irel Route Number
Division	after d Direct J in by	determined 28e. Piece of Injury - At no building, etc. (Specif)		City or Town, State)	rennoute rannoer,
_	To the Hospital or Attending Physicien: The law within 24 hours after deeth. To the Funeral Director: After this certificata has completely filled in by the funeral director, page 2	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.	wledge, deeth occurred at the time, date and place, tion end/or investigation, in my opinion, death occurr	end due to the cause(s) and manner as ed at the time, date and place, and due	stated. to the cause(s)
	o the vithin 2 or the comple		29c. License number	29d. Date signed (Month	ı, Day, Year)
		Walin O armen	D35206	May 27, 2	2006
7	(2)	30. Name end address of person who completed cause of death (Item	1 23e) (Type, Print)		20744
_	w	Dr. William Tanner MD		ingston Road, Fi	t. Wash MD
ı	State Registrar		Spell		

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 State
Registrar-Amend#19a.PerInfinnt.PGC 6-13-06 cr Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 2<u>006</u> **Physician** 5, June 6:50A Calvillo Alfredo R. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ft. Washington Prince George 13900 Piscataway Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 9 (Month Days Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Minnesota 1 X M 2 □ F 513-32-1695 66 Director Usual Residence of Decedent 10d. Inside City Limits death with the Manyland 10c. City, Town or Location 10a. State 10b. County ral, or items 23s or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Ft. Washington Maryland Prince George Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20744 13900 Piscataway Dr. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 \(\text{No.} 1 957 - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1⊠Yes 2□No Specify: Mexican Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Hispanic þ 1962 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Mudical eges 1 and 2 should be filed within 72 hat of Health and Mental Hygiene.
If item 27 is marked other than "natu or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Mental Health Psychologist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Florence Ramos Calvillo Frank G. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print)
Marianita A. Pardo
'Mariana Calvillo/Wife 13900 Piscataway Dr. Ft. Wash. MD.20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Peges 1 1 Burial 2 Cremation 3 Removal from State 6/6/06 Edgewater, MD. permit. Pege Department of Important: If any injury or ODCE. Kalas Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Geo. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 21. Signature of Funeral Service Licensee ALM. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Esophogeal Cancer months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day jo in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) detached 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 XNo this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□ No Certification: To in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident hours after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD33037 June 5, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 3800 Reservoir Rd. Wash. DC 20007 Andrew T. Putnam, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 0 7 2006

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month June 2008 7:52A Thien Can Hoang /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
July 9, 1941 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Vietnam 64 586-44-6368 Yrs. Director Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Maryland Silver Spring Montgomery Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 United States of America 1100 Kersey Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Asian 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) other then Medical Doctor Medical permit. Pages 1 end 2 should be filed w Department of Heelth and Mental Hygier Important: If Item 27 is marked other theny or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ngoctu Congtang Toai Hoang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Kersey Road, Silver Spring, MD 20902 Minhha D. Hoang - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 06/10/06 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service Licensee 22. Name and Address of FacilityHines Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. 5 feet to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): **Examiner** Left Hip Infection Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) g physicien and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🗓 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? t ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Anpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D063738 June 6, 2006 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Ara Anjuman, MD

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

2006

			. For	State of Ma					-	giene o o c	10769
		_	1 - State Registrar		-	ertificate			R	leg. No. UUO	19102
H	Physici	an	1. Decedent's Name (First, Middle, Last						2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examin	al	ANTHONY ANDREW 4a. Facility Name (If not institution, give	CIANELLI street and number)		4b. City.	Town, or Loca	ation of Death	06	4c. County of Dea	
	EXAMI	ei	WASHINGTON COUNTY				HAG	ERSTOWN		WASH	INGTON
	Funeral		Social Security Number 6. Se	x 7.Age STM 2□F	(In yrs. last birthd	Months		ours Min.	8. Date of Birth (Month, Day	9. Bi	thplace (State or Foreign ountry)
	Director		217-12-2648 Usual Residence of Decedent		81				EC. 13	, 1924 PE	NNŚYLVANIA
	arylan show	L	10a. State 10b. County		10c. City, Town o						10d. Inside City Limits 11 Yes 2 No
	the Ma	Director	MARYLAND WASHING 10e. Street and Number	TON		10f. Zip	AGERST	OWN		10g. Citizen of What C	
	3a or		236 HAGER STREET			101. 2.10	2174	40			S.A.
	ams 2	Funeral	11. Marital Status	12. Was Decedent En	ver in U.S.	3. Was Deced			cify Yes or No- Rican, etc.)		erican Indian,
36	hours after death with the Maryland turai, or Itams 23a or 28e-f show al Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1943- 1946	1 ☐ Yes		ecity:	,	Specify	WHITE
9	i within 72 hours after death with the Marylan itan. r than "naturel", or Itams 23a or 28e-1 show the Madical Examiner must be notified at	ted t	15. Decedent's Edi	ucation		cedent's Usua	l Occupation		_	16b. Kind of Business	
215	within 7 ane. than "n	Completed	(Specify only highest grad	College (1-4or 5+	·)			nost of workir	ng		
d 21	be filed w stat Hygian of other ti		17. Father's Name (First, Middle, Last)	,		OPERAT	1		(First, Middle,	CONSTR Maiden Surname)	UCTION
au	d be entate ked o	To Be	ANTIONIO CIANELLI				A	NNA LOU	ISA DAL	ΈY	
Maryland 21215-0036	she and le m		19a. Informant's Name/Relationship (T				,			r, City or Town, State,	
	s 1 end 2 f Health item 27 other tr		HELEN V. CIANELLI 20a. Method of Disposition	/SPOUSE	236 20b. Place of Di				-	MARYLAND 20c. Location - City of	21740
Baltimore,	ges it of if it or o		1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify		BOONSBO	crematory or or	ther place)	6/12/		BOONSBORO,	
alti	artm orts inju		21. Signature of Fyheral Service Licens	600		22. Name an	d Address of I	Facility 7		National	
8	Dep Imp		and My Coll	, ecc	1. Dean	BAST F		HOME B	oonsbor	o, Marylan	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused t ne cause on each line	he death. Do not	enter the mode				est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	consequence of):	MAY	ECLASI	OLISM	/		20 HOURS
	Examiner		Sequentially list conditions	b							
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):						
	ite be executed ysician and ne burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
3760,	ysicia he buri	cal	(d							
89 x	eath certificat ettending phy I for use as the	Med	IF FEMALE:	220 15 100 011000000	4 mm mm m m m m m m m m m m m m m m m m						
Вох	leath c ettend	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death	3 Ectopic pro				23d. Date of de Month	livery Day Year
P.O.	at the de by tha tached	Physician/Med	9 Unknown	9□ Unknown							
	The law requires that the death certifical tie has been signed by tha ettending phyage 2 should be detached for use as the	ğ	Part II. Other significant conditions co	ntributing to death but	t not resulting in th	e underlying ca	ause given in I	Part I.	23e. Did tol	bacco use contribute t es 2 € No 3 □ P	o the cause of death?
Sor	w requir been s	letec	DICIFA	SE	co p.o.	~(VII)/	7 H/C/		24a. Was a	_	utopsy findings available
Re	The lav	Completed							autops	med? prior to death?	completion of cause of
ital		Be C	25. Was case referred to medical examiner?					Place of Death	(Check only on		2010
_	sic sic	- T	1 Yes 2 No	Hospital: 1 Impatien						ence 6 Other (Spe	ocify)
ion	Attending r death. ector: After by the funer	atlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) Inju	y M	8c. Injury at Work? 1 ☐ Yes		ou. Doscribo III	ow injury occurring	
Division of Vital Records,	tel or Attending PI s after death. al Director: After the ed in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	ry - At home, farm, (Specify)	street, factory	, office	2	8f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
Ω	Hospitel o		29a. Certifier 1 Certifying Phy	rician: To the best of	f my knowledge d	nath convered	at the time de	ate and place of	ad due to the a	ause(s) and manner a	
	To the Hospitel or Atti within 24 hours after de To the Funeral Direct completely filled in by ti	Medical	(Check only 2 Medical Exam	iner: On the basis of and manner state	examination and/o	r investigation,	in my opinion	n, death occurre	d at the time, d	ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier	1/A /)	1 0/ -	29c	. License num	nber		9d. Date signed (Mon	th. Day, Year)
,			Woher Bull M	W rensonal	Physica	an	DU	435	1 3	JUNE 8	2006
51	1-12+1		80. Name and address of person who c	59 PATAM.	atn (item 23a) (Ty	pe, Print)	KAG	PITOU	IN M	n 2174	62
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1	S VI VOICE	~ / 000	666	0-1-11	
1	Registr	ar	JUN 0 9 2	006 Janear	~ B.	Specie					

			For State Registrar	State of Maryland		artment of H		nd Mental F	lygiene ()	06	19763
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Month	Day	Year	3. Time of Death 10:53 A M
	/Medic		Alice Davis Clark 4a. Facility Name (If not institution, give sti	reet and number)		4b. City, Town, or	Location of D	Death Death		ty of Death	10.3311
4	Examin	er	Doctor's Community			Lanham		V	Princ	e Geor	rge's
4	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of (Month,	Day Year)	Count	ace (State or Foreign
	Director		3/7-24-0082	M 2 🗓 F 83	Yrs.			June	4, 1923	Washi	ington, DC
	and and	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside City Limits
	Maryi -f aho lied a	tor	Maryland Prince Geo	orge's Bow	ie						XXYes 2 □ No
	r 28a	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?
	th with		14107 Wainwright Co	ourt		20715			USA		
	r dea	Funeral	TI. Walled States	2. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin In, Mexican, P	n? (Specify Yes or Puerto Rican, etc.)	No- 14. Ra Bla	ace - America ack, White, e	
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Speci	ify: Wh-	ite
21215-0036	within 72 hours after death with the Maryland ane. Than "natural", or Itame 23a or 28a-f ahow ha Madigal Examiner must be notified at	ed t	15. Decedent's Educa	ation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of E		
212	hin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		kind of work done of DO NOT use retired	during most of f)	f working			
ด	ed wit	Соп	12		Home	Maker			Own Ho		
nd	be filed with the beat the bea	Be	17. Father's Name (First, Middle, Last)						dle, Maiden Suma	me)	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental hygiene. Is marked other than "natural", or itame 23a or 28a-f show eumatic avent, the Medical Examiner must be notified at	은	Joseph E. Rivers 19a. Informant's Name/Relationship (Type	a Print)	19b Mailie	ng Address (Street a		B. Reid	mher City or Tour	n State 7in	Codel
Z Z	p ⊆ ► =		Alvin J. Clark/ Hus			Wainwrig					Codey
ē,	1 an Hea		20a. Method of Disposition	20b. P	ace of Dispo	sition (Name of		Date	20c. Location		wn, State
Baltimore,	Pages nent of t int: if it		1 Durial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval moni State	Mar	matory or other plac cyland Cemetery		5/12/2006	6 Chelte	nham	MD
alti.	mit. I partm porta r inju		21. Signature of Funeral Service License	A	22	2. Name and Addres					
m —	Depa Impo any ir		1 FILL			6000 Anna					
1	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	,	er the mode of dyin		rdiac or respirator	y arrest,	į.	Approximate Interval Between Onser and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ		TYCA					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
8760,	ate be executed hysicien and the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):						
387	physi s the t	edical	d.								
Box 6	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna					23d. D	ate of delive	ry
P.O. Bo	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown		⊒Ectopic pregnancy ☐ Other (specify)				fonth I	Day Year
ď.	aned to	by P	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. D	id tobacco use cor	ntribute to the	e cause of death?
ord	w require been si should b	bed	Company Amer	y Discere				1	☐ Yes 2 ☐ No	3 🗌 Proba	ably 4 Unknown
Records,	e taw r has be je 2 sh	Completed						24a. W	utopsy	prior to com	osy findings available npletion of cause of
<u>~</u>	: The	Son						1 ☐ Ye	erformed? s 22 No	death?	25 No
Vita	Physiclen: r this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Othe		f Death Check on			
ot	Phye r this ral dir	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b, Time o				esidence 6 Ot)
O	th. : Afte	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Inju <i>r</i> y	f 28c, Injun Worl	k? Yes 2∐No				
Division of Vital	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, sti	reet, factory, office			n (Street and Num Town, State)	ber or Rural	Route Number,
	To the Hospitel or Attending Physicien: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C		ician: To the best of my kno er: On the basis of examina and manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	/		29c. License		7	29d. Date sign		
			WIMMLE			04.	160	>	yun	re 6,	200E
			30. Name and address of person who con	mpleted cause of death (Item	23a) (Type,	Print)	11 17	1000	1.	7	2006
1	Sc. (20)		31. Date filed (Month, Day,	1Ce VADO 40	ture A-	sterfler,	14 14	1 13/16	150WC	0,200	107/6
	Sta Regist		Date find finding Day	7 (00)	J. 15	April					

			1 – For State Registrar	State of Ma	aryland /		ment of H		Mental Hyg	giene 200	6 19764
	-		Decedent's Name (First, Middle, Las	t)			10010 01 1		2. Date of Dea	ith	3. Time of Death
	Physici		Agnes	T	huro	6:11	(Month	OF 20	06 0940 M
)	/Medio Examir		4a. Facility Name (If not institution, give			. 1 4	b. City, Town, or	Location of De		4c. County of D	
	Ladiiii		Shady Grov	e Adve	NHST	Hosp	ital	Rockv:	ille	Montgo	omery
	Funeral		5. Social Security Number 6. Se		e (In yrs. last		f Under 1 Year Ionths Days	If Under 24 H Hours M		(Year) 9.	Birthplace (State or Foreign Country)
	Director		060-20-5854	□M 2□F	79	Yrs.	Ontris Days	Tiours ivi	April	12, 1927	Pennsylvania
	Du 💌		Usual Residence of Decedent 10a, State 10b, County		10c. City, To	own or Locat	ion				10d. Inside City Limits
	laryla eho	ă					1011				1√2 Yes 2 No
	28a-f	Director	California Orange		Tust		10f. Zip Code			10g. Citizen of What	A
	hours after death with the Maryland tural; or Items 23s or 28s-f show al Examiner must be notified at							700			•
	eath	Funeral	14321 Clarissa La	12. Was Decedent	Ever in U.S.	13. Wa		2780 ispanic Origin?	(Specify Yes or No-	U.S. A	A •
	fter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉		If Y	es, specify Cuba	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, W	Vhite, etc.
036	urs a	Ď	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆	Yes 21 No	Specify:		Specify: \	<i>N</i> hite
Ō	n 72 hours "natural", adical Exe	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16	6a. Deceden	t's Usual Occup d of work done	ation	unrking	16b. Kind of Busine	ess/Industry
218	C _ 38	pie	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO	NOT use retired	i)	rorking		
21	filed withir Hygiene. other then	S	12			Secr	etary				California
nd	e d la b	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle,	Maiden Sumame)	
<u>y</u>	D & 3 0	၉	William Chim					Agne			
-	~ ~ ~		19a. Informant's Name/Relationship (7				Address (Street	and Number or	Rural Route Numbe	r, City or Town, Stat	re, Zip Code) 92780
	f Health Item 27 other tre		Kelly D. Thompson 20a. Method of Disposition	- Daughte	r-in-	1aw	14321 C	larissa	Lane, Ti	istin, Cal 20c. Location - City	
وّ	8 o T -		1 ☐ Burial 2 ☑ Cremation 3 ☐		1		on (Name of ory or other place			•	
			4 ☐ Donation 5 ☐ Other (Specify 21. Signatur of Funeral Service Ligen		Metro						a, Virginia
Ва	permit. Departr Imports any inju	H	N J - T	1661.						Funeral Ho	
			23a. Part 1. Enter the disease, or comp	lications that caused	the death D	264	01 Ridge	Road,	Damascus	, Maryland	d 20872 Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	10.		~ ·		as or roopmatory are	551,	Interval Between Onset and Death
) 1	Physician /Medical		disease or condition resulting in death)	w	10000		Embo	112 W			2 Days
	Examiner			Due to (or as	creat	0	Cane	CD.			Vanage
		2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as			Curio	-			1 Fears
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c.							
ó	exec en an riai-tr	Exa	resulting in death) Last	Due to (or as	a consequenc	ce of):					
8760	ate be executed hysicien and the burial-transit	dical		d.							
99	ntifica ng ph	Med	IF FEMALE:								11.
Box	ath certific attending p for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		ath 3∏Eo	topic pregnancy			23d. Date of	
E	at the dea by the at tached fo	Physician/Me	1 Yes 2 No	4☐ Pregnant at 9☐ Unknown	time of death	5 🗌 O	ther (specify)			Month	Day Year
P.0	that the	Ph	Part II. Other significent conditions co	entabuting to double by	ut not socultion	n in the ward	ah da a a a a a a a a a	on in Donal	220 Did to	haasa uga sastiibut	e to the cause of death?
JS,	o o	þ	Renal Fa	· (ut not resulting	g in the unde	mying cause give	en in Pan I.	23€. Did to	V	Probably 4 Unknown
orc	w requir been si should	ompieted	rena ra	NURZ					-		
3ec	elaw hast e2s	μ							24a. Was a autop:	sy prior	autopsy findings available to completion of cause of
<u>=</u>		S							perfor 1 ☐ Yes	med? death 200 No 1 □ Y	res 200 No
of Vital Records,	Physician: This certifica	Be	25. Was case referred to medical examiner?	Hospital:			Oth	200	eath Check only or		
ō	Phys this raidii	. T	1 Yes 2 No	28a. D te of Inju		Outpatient o. Time of		4 🗆 Nursing		ence 6 Other (S	ipecify)
	ding i h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Pa)	Year)	Injury	28c. Injun Work	Yes 2 □No	28d. Describe fi	VIA	
Division	Attending r death.	fica	3 Suicide 6 Could not be	28e. Place of Init	ury - At home.	farm, street			28f. Location (S	treet and Number or	Rural Route Number,
=	al or Attandii s after death. al Director: A sd in by the fu	Certification:	4 Homicide determined	building, etc	c. Specify)				City or Tow	n, Staje)	, and the state of
	in the state of th		29a. Certifier 15 Certifying Phy	sician: To the best	of my knowled	ige, death oc	curred at the tin	ne, date and pla	ce, and due to the c	ause(s) and manner	as stated.
	To the Hos within 24 h To the Fur completely	edicai	(Check only 2/ Medical Exam one)	iner: On the basis of and manner sta	examination	and/or inves	tigation, in my of	oinion, death oc	curred at the time, o	ate and place, and o	tue to the cause(s)
	To the I within 2 To the Complet	Ž	29b. Signature and title of certifier	R	0		29c. License	~	2	9d. Date signed (Mo	onth, Day, Year)
	1		1 PCOC	110	L 1	MD	644	107		6 7 1	06.
	5		30. Name and address of person who o	ompleted cause of d	eath (Item 23a	a) (Type, Prir	nt)	01	0 . 1	0. 0	1 11
) lock	s Kd	Site	200 K	ockille MD
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 8 2		ar's Signature	Solo	de	,		/	

			For State Registrar	State	of Marylar				lealth a Death	and M		giene Reg. No. (2006	dada yan	9765
	,8"		Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	ath	Year	3. Tin	ne of Death A
	Physicia		Mary Virginia	Morsberge	er Coope	r					June	7 ay	2006	03	:05 M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and n	umber)	-	4b. City	, Town, or	Location o	f Death		4c. (County of Dea	th	
			Washington Cou	nty Hospi	ital		Ha	gerst	own				lashing	ton	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Und Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v, Year)	9. Bir	thplace (St	ate or Foreign
	Director		212-74-2834	1 □ M 2 🔀 F	93	Yrs.					JAN 18	1913	3 Bru	nswi	ck, MD
	and W	1	Usual Residence of Decedent 10a, State 10b, County	,	10c. Ci	ty. Town or Lo	cation							10d. Insid	de City Limits
	daryla	ក		derick		Brunsw:	ick							1 😡	Yes 2 ☐ No
	the N	Director	10e. Street and Number	deller		DIGIISW		ip Code				10a. Citiz	zen of What Co	ountry?	
	with be or	ă		reet				1716				_	ISA	,	
	leath	Funeral	11, Marital Status	12. Was De	ecedent Ever in L	J.S. 13. V	Was Dec	edent of Hi	ispanic Orig	gin? (Spe	crfy Yes or No-		4. Race - Ame	erican India	ın,
	hours after death with the Maryland tural; or Itama 23a or 28a-f ehow al Examinar must be notified at	Fun	1 ☐ Never Married 2 ☐ Mar	ried 1 ☐ Yes	2 XNo					, Puerto l	Rican, etc.)		Black, Whit		
8	al', o	by	3 XWidowed 4 ☐ Divorced	If Yes, 0 Year or			1 🗌 Yes	21 X I No	Specify:				Specify: W	iile	
2	72 ho	Completed	15. Deceder (Specify only highe	nt's Education	d)	16a. Dece	kind of w	ork done o	durina most	t of workii	ng	16b. Kin	nd of Business	/Industry	
7	within 72 ene. then na	npi	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT	use retired	1)			77			
2	led w lygier her ti		12	1		П	ouse	vile	19 Motho	r's Nama	(First, Middle,		memake	r	
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan of Mental Hygiens, marked other then "natural", or flams 23a or 28a-f ehow marked other then "natural", or flams 12a or 28a-f ehow marked event, the Madical Examinar must be notified at	Be	17. Father's Name (First, Middle,								rnette	Waldell .	Surrame)		
چ	should and Men marks umatic	2	John Henry Mor 19a. Informant's Name/Relations	_		10h Mailir	a Addro	c (Street			I Route Numbe	r City or	Town State	Zin Code)	
<u> </u>	d 2 sl th and 7 le r		Mary Ann Daugh		ughter		_				Knoxvi			1758	
o,	as 1 and 2 should b of Health and Ment I Item 27 le marked r other treumatic e		20a. Method of Disposition		20b. I	Place of Dispo	sition (N	ame of			ate		cation - City or	Town, Sfa	te
altimore,	permit. Pages Department of Importent: If It any injury or o		1 Surial 2 ☐ Cremation		m State	cemetery, crer ark Hei				6/10	1/06	Reur	nswick,	MD	
틀	rt. P		4 Donation 5 Other (S		1.11/11				ss of Facility		700	Drui	.ISWICK,	гц	
Ba	Dep Imp		THAMAIN IC	Williams,	. Owner	ne	John	T. W	illia	ms F	uneral			217	1.6
			23a. Part1. Enter the disease, o shock, or heart failure. List			th. Do not ent	er the m	de of dyin	g, such as	cardiac o	ad, Bru or respiratory ar	rest,	CK, MD	Approx	rimate
	Dharatatan		shock, or heart failure. List Immediate Cause (Final	t only one cause or	n each line.	Pinti	Tim	19	nles	G-101.	. \			Onset	al Between and Death
	Physician /Medical		disease or condition resulting in death)	aDue t	o (or as a consec	nuence of):	W U	(0)	N FC C	(1000	,)			18 1	DAYS
	Examiner				Selosis									上类C	AY
4		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due t	o (or a consec	quence of):									
	outed nd ransit	Examiner	Cause (Disease or injury that initiated events	G	Precur	nia								4 4	sceles
o,	e exe ien ar irial-t		resulting in death) Last		o (or as a consec		1-1	gialia.	180						
8760,	cate be executed physicien and the burial-transit	dicai		d.	lin ish	u Ha	mt-	Country	14-					YE	ARS
9	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Med	IF FEMALE:	1	M							-			-
<u>@</u>	ath ce ttendi	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregn birth 2 Pet	aldeath 3□		pregnancy	,			2	3d. Date of de Month	livery Day	Year
P.O. Box	that the death certificed by the attending properties detached for use as	Physician/Me	1 ☐ Yes 2 X No 9 ☐ Unknown	4∐Pre 9□Uni	gnanf af time of known	death 5	Other (specify)						,	
<u>a.</u>	hat the d by Jetac	Æ	Part II. Other significant conditi	ions contribution to	death but not re-	sulfing in the u	nderlying	cause div	en in Part I		23e. Did to	obacco u	se confribute to	the cause	e of death?
Division of Vital Records,	signe signe d be d	by	Tattil. Other signment contact	one commoning to	doddi bar nor ro	ouning in the d	riadiny in ig	oddoo giv	OIT III T LIKE I.			res 2			4 Dunknown
Ö	w requires t been signe should be	ete													/.
ခွ	elaw hast	Completed									24a. Was autop		prior to death?	completion	lings available of cause of
<u>=</u>	n: The										1 ☐ Yes	2 No	1 🗆 Yes	2 □ No	1
₹	Sicien) Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Discovery of	7.CD/O		Cth	or		(Check only o		TO# (2-		
ō	Phy r this	. To	27. Manner of Death	28a. Dai	te of Injury	ER/Outpatier 28b. Time o		28c. Injun	y at		me 5 Resid			iciry)	
9	th. Afte	tio	1 Natural 5 ☐ Pendi 2 Accident invest	ing (Mo	onth, Day Year)	Injury	М	Wor	k? Yes 2 🔲!	No		-			
<u> S</u>	Attending Physicien: Ir death. ector: After this certifici by the funeral director.	fice	3 ☐ Suicide 6 ☐ Could	mined 208. Fld	ce of Injury - At I		reet, facto	ry, office			28f. Location (S	Street and	d Number or R	ural Route	Number,
á	a afte	Certification;	4 Homicide	Dui	ilding, etc. (Speci	iry)					City or Tox	m, State)			
	Hospital 24 hours a Funeral I			ing Physician: To t											
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	Medicai	(Check only 2 Medical one)	I Exeminer: On the and ma	anner stafed.	ation and/or in	vestigatii	n, in my o	pinion, dea	th occurr	ed at the time,	date and	place, and du	o the cat	158(S)
	To the within 2 To the complet	Σ	29b. Signature and title of certific	er *	,	3	2	9c. Licens	e number			29d. Date	e signed (Mon	th, Day, Ye	ar)
	0		MR	edu)	MI)		1)	4656	1		06	.07	= 20	06
	5		30. Name and address of person	who completed ca	ause of death (Ite			· N	200	11	14 101 15	71.1	MO	01	71.
			GHALACA 31 Date filed (Month Day Very	WADIR 32	Agistraria Si-		PETW	A RE	JH)	17	MENUTO	NW	עוויו	d	140.
	Sta Regist		31. Date filed (Month, Day, Year JUN 0	9 2006	. egistrar's Sign	J. A.	204								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Month 2006 **Physician** 1130 CHERRINGTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF Days Hours Min Yrs. 68 Director Feb. 28, 1938 Jamaica, 154-78-2876 Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State 28e-f show other treumatic event. The Medical Examiner must be notified at 1 XYes 2 ☐ No Director New Jersey Union Union 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 07083 USA 1077 Overlook Terrace Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: 3X Widowed 4 ☐ Divorced Black and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Health Care 12th Nursing Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orinthia Asphall Nathaniel Skyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) it of Health 52 Woodside Road - Maplewood, NJ Melanie Virgo/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ō Department of Importent: If any injury or once. * 4 □ Donation 5 □ Other (Specify) Hollywood Mem. Park | 06/10/2006 Union. New Jersey 21. Signatur Funeral Service Licenses 22. Name and Address of Facility1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ulmana Pnysician disease or condition resulting in death) /Medical ue to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Pan The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Rena 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 1 ☐ Yes Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No death. 2 Accident after death Director: 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 24 hours a

1906/80

State Registrar

JUN 08

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Guarni eri

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atlantic 32. Registrar's Signature

Gener Homital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D006364

Healthur

29d. Date signed (Month, Day, Year)

within 24 ho To the Fun completely f

To the

		For State Registrar	State of Mary		artment of H tificate of L		Re	g. No.	06 1976
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) Hurshe Aa. Facility Name (If not institution, give to Doctors Community)	e11 Yvonne	Davis	4b. City, Town, or		2. Date of Death Month MAY	Day 3/ 2 4c. County	Year 3. Time of Death 3. 45 P of Death ce Georges
Funeral Director		5. Social Security Number 6. Sec	7. Age (In	n yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, June 2,		9. Birthplace (State or Ford Country) Virginia
ith the Maryland or 28s-1 show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 0		c. City, Town or Lo	nsburg				10d. Inside City Lin 1 X Yes 2 □
ath with th	rai Dire	10e. Street and Number 5028 - 57th Avenu	ie; Apt. 20		10f. Zip Code 20710			_	Vhat Country? States
and Z1Z15-UU30 be filed within 72 hours after death with the Maryland thygiene. do other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cubai I ☐ Yes 2XX No		pecify Yes or No- to Rican, etc.)		e - American Indian, ck, White, etc. g: Black
1 Z 1 3-v	mpletec	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th grade		(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	tion uring most of wo	rking		usiness/Industry
Maryland Z1Z15-UU30 nd 2 should be filed within 72 hours aft lith and Mandal Hygiens Z7 ie marked other than "natural", or reaumatic event, the Medical Exam	To Be Co	17. Father's Name (First, Middle, Last) Otis Davis		П	OMEMAREI	18. Mother's Nar	me (First, Middle, M.	aiden Sumam	(9)
and 2 short y ealth and N m 27 ie ma		19a. Informant's Name/Relationship (Ty Keisha Donique Day	is (Daught	er) 5028	- 57th Av		t.203;Bla	densbu	
Baitimore, Maryland 21213 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "In any Injury or other treumatic event, the Medi		20a. Method of Disposition 1	emoval from State	Cedar Hi	LL Cemete: . Name and Addres	y June		Suitla	City or Town, State nd, Maryland
PA (DO, licate be executed I/Medical Examiner but but and is the burial-transit	edical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	ATIC onsequence of): AGULO	ENCE		HTAGO	۲	Interval Between
COIDS, P.O. BOX OR wrequires that the death certificate been signed by the attending phenould be detached for use as the should be detached for use as the state of the state	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat	e of delivery nth Day Year
quires that in signed build be deta	by	Part II. Other significant conditions cor	ntributing to death but no	ot resulting in the ur	nderlying cause give	n in Part I.			ibute to the cause of death
	piet						24a. Was an autopsy performe	ed?	Vere autopsy findings avairior to completion of cause leath?
al HeCO 1: The law re icate has be r, page 2 sho	Completed)	Yes 2 No
r VITAI HECO ysicien: The law re is certificate has be director, page 2 sh	Be	25. Was case referred to medical examiner?	lospital:	2 ER/Outpatien	t 3 DOA Othe	•	ath <i>(Check only one)</i> Iome 5□ Residen		
IVISION Of VITAI RECOIDS, P.O. BOX OF Attending Physicien: The law requires that the death certificate death. rector: After this certificate has been signed by the attending ph to by the funeral director, page 2 should be detached for use as the page of the funeral director.	To Be	examiner?	dospital: Inpatient 28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (S	28b. Time of Injury At home, farm, str.	28c. Injury Work	r: 4 🗆 Nursing H	lome 5 Residen 28d. Describe how	ce 6 Other	er (Specify)
DIVISION Of VITAI RECORDS, P.O. BOX 68/60, Hospital or Attending Physicien: The law requires that the death certificate be expanded at the death certificate be expanded at the death. A hours after death. From the form of the first certificate has been signed by the attending physicien stell birector. After this certificate has been signed by the attending physicien stell in by the funeral director, page 2 should be detached for use as the burial directory.	Certification: To Be	examiner? 1 Yes 2 No F 27. Manper of Death 1. Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Exami	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (S	28b. Time of Injury At home, farm, stropecify) by knowledge, death amination and/or in	28c. Injury Work M 1 Y	r: 4 □ Nursing H at ? es 2 □ No	28d. Describe how 28f. Location (Stre City or Town,	oce 6 Other injury occurred and Number State)	er (Specify) ed er or Rural Route Number,
DIVISION Of VITAI HECO To the Hospital or Attending Physicien: The law re within 24 hours after death. To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sho	To Be	examiner? 1	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (S	28b. Time of Injury At home, farm, stropecify) by knowledge, death amination and/or in	28c. Injury Work M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4 Nursing F at ? es 2 No e, date and place	28d. Describe how 28f. Location (Stree City or Town, a, and due to the cautred at the time, dat	winjury occurr set and Number state) use(s) and ma e and place, a	er (Specify) ed er or Rural Route Number,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE **Physician** 1 2006 DAVIS ANDREA MARIA 10:27 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7100 DECATUR STREET LANDOVER HILLS PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Days Hours 1 □ M 21 F Director 214-88-8408 DEC 15 1961 WASHINGTON, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County or then "natural", or items 23s or 28s-f ehow the Mudical Examiner must be confilled at 1X Yes 2 ☐ No Director PRINCE GEORGE'S LANDOVER HILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7100 DECATUR STREET 20784 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISTRIBUTION CLERK GOVERNMENT 12th h and Mental Hygie 7 Is marked other t permit Pages 1 end 2 should be filed.
Depertment of Health and Mental Hygis Important: If them 2.7 le marked eny injury or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM JOSEPH DAVIS DOROTHEA V. CARTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDRE DAVIS/SON 7100 DECATUR STREET LANDOVER HILLS, MARYLAND 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 6/8/2006 4 Donation 5 Other (Specify) CLINTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 29785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4□ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be c þ Mitral Valve Replacement Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificete 2X No 2K No 1 Yes or Attending Physician: After this certific funeral director, 25 Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 E Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 🗀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) hunte, or 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) centerway Greenbelt, or 20170

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 7

2006

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2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 6 2006 10:56 A M Roland Lee Epps June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 10,1916 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F Months Days Hours Yrs. Director 102-07-4031 90 Mass. Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10h County 10d. Inside City Limits r than "natural", or Items 23s or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Prince George's Glenn Dale 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20769 USA 6206 Darrowberry Court death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Postal Carrier U.S. Postal Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liquy or other treumatic event 2008. Be Mable Jane Bristow Richard Lee Epps ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6206 Darrowberry Ct. 20769 Glenn Dale, MD. Gail Epps / niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Barnabas Cemetery 06/10/2006 Upper Marlboro, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Lice 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colo-Rectal Cancer 1 week /Medical Due to (or as a consequence of) Examiner Metastatic Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physicien and for use as the burial-transit so the Hospitel or Attending Physician: The law requires that the death certificate be executed 1 week Gastrointestinal bleeding Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed to should be deta Part ft. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has autopsy performed' Dementia 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA this After this 27. Manne of Death 1 Naturat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manper stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D13671 June 7, 2006 who completed cause of death (Item 23a) (Type, Print) B.G. Manejwala, M.D. 14201 Laurel Park Dr. # 102 Laurel, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 8 2006 Registrar

			For State Registrar	State	of Marylan		artment of F		ınd Me	ntal Hy	giene, Reg. No.	2006	1977	0
W	Dhysisi	an	1. Decedent's Name (First, Middle,	Last)					2	. Date of De	ath Day	Year	3. Time of Death	h
	Physici /Medio		Winifred R. F							June 6		16	5:25 A	М
	Examin	ier	4a. Facility Name (If not institution, s Anne Arundel. M				4b. City, Town, o		f Death		1	County of Dea ne Aru		
				. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	Il Under 2	24 Hrs. 8	. Date of Bir				9 <i>ia</i> n
	Funeral Director		223-36-8221	1□M 2 X F	78	Yrs.	Months Days	Hours	Min.	Date of Bir (Month, Da 7-17-	19, Year)	We	rthplace (State or Fore ountry) est Virgini	ia
100	p ,		Usual Residence of Decedent			ty, Town or Lo								
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	the N 28a-f	Director	10e. Street and Number	ALGIGET		TIGE WOO	10f. Zip Code				10g Citiz	en of What C		
	3a or		879 Conservation	n I.n			20776	5			-	USA	,	
	death	Funeral	11. Marital Status		edent Ever in U	.S. 13. \	Was Decedent of H		gin? (Specif	fy Yes or No			erican Indian,	
õ	or it	y Fu	1 Never Married 2 Married	d 1 ☐ Yes If Yes, G	2 X) No	}	1 ☐ Yes 2 🕱 No	Specify:	,	Juli, 5(5.)		Coop if		
0500-6121	ture!	ed by	3 X Widowed 4 ☐ Divorced 15. Decedent's	Year or I	Dates:	16a Docor	dent's Usual Occup	ation				d of Business	White	
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yiand	d oth	Be	17. Father's Name (First, Middle, La		_					First, Middle				
Z	Man Marke Marke Marke Marke	ပ္	Robert Mi	•	nd .					laude				
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importment if them 27 le marked other than "naturel", or items 23e or 28e-f ehow any injury or other traumatic event, It a Medical Everthan mail the notified at ance.		John T. Frank/				ng Address (Street Murray I		_				Zip Code)	
ā,	s 1 an I Heal tem 2 other		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place	al .	Date	ө	20c. Loc	ation - City or	Town, State	
Hore	Pages ent of nt: if ry or		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐Removal from cify)	State		ion Cemet		-9-06	5	Cli	nton,	MD	
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<u>n</u>	89 2 2 3		In UM			2	973 Solo	ions I	sland	Rd.	Edgew	ater,	MD 21037	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that by one cause on	caused the deat each line.	h. Do not ent	er the mode of dyin	g, such as c	cardiac or r	espiratory a	rrest,		Approximate Interval Between Onset and Death	
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A Company		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	uence of):								
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	ilcian: Th certificate rector, pag	ဝိ	25. Was case referred to medical					OC Disease	of Dooth //	1 Yes	2 🙀 No	1 ☐ Yes	s 2□ No	
5	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Oth			Check only of 5 □ Resi		□Other (Spe	acify)	
0	ding Physin.		27. Manner of Death 1 S Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury		/ at	280	d. Describe	how injury	occurred	,,	
DIVISION	tendii eath. or: Ai the fu	catic	2 Accident investiga 3 Suicide 6 Could no	tion				Yes 2□N						
₹	or At after d Direct in by	ertification;	4 Homicide determin	ad 286. Place	e of Injury - At his ling, etc. (Specif	ome, farm, str y)	eet, factory, office		281	City or To	Street and wn, State)	Number or R	ural Route Number,	
_	spital	O	29a. Certifier 1 Certifying	Physician: To th	e best of my kno	wiedge, death	occurred at the time	ne, date and	place, and	d due to the	cause(s) a	ind manner a	s stated	
	To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Ex	caminer: On the b	pasis of examina nner stated.	ition and/or inv	vestigation, in my o	pinion, death	h occurred	at the time,	date and p	place, and du	e to the cause(s)	
	To the within To the Comp	M	29b. Signature and title of certifier	is a Beid	(MA)	·	29c. Licens		3		29d. Date	signed (Mon	th, Day, Year)	
				revi Bert			70	4605				10100		
			30. Name and address of person with the second seco	o completed cau	se of death (Item 2001 W.E.	n 23a) (Type,	Print) achway	Cenha	Holy	HD				
	Sta	ate.	31. Date filed (Month Day Year)				71			/		-		
	Regist		JUN 0 7 2	UUb A	Registrar's Sign	A Soo	Se de							

06-041/2 Joseph Edward Foster, II

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene	200
Certificate of Death	6 U U

		1- For Stat e Registrar 1. Decedent's Nam	o /First Middle	2 Locat)		Certific	cate of	Death			I à	Date of De	Reg No	2.			(5.11
nysicia: Examin		Joseph	e (i iist, iviiddit	Edward		F	oster	: II				Month June 16,	Day			1145	of Death hrs
		4a Facility Name (Route 648			umber)		4	b. City, Town, o Linthicum	or Loca	ation of De	eath		1	ic. County o Anne Ari			
neral ector		5. Social Security (6. Sex 1 X M 2 F		n yrs. last bir	rthday) Yrs.	If Under 1 Ye Months Da			Min.	Date of E		M/DD/YYYY 1963	Foreign	olace (S	
any	F	Usual Residence of	f Decedent 10b. County		100	c. City, Town	n or Locatio	on	_						11	0d. Insi	de City Limi
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r items	Funeral	1 Never Marri	ied 2 Ma	Armed F				es, specify Cuba					•0-	White		n india	i, black,
£ 5	βF	3 Widowed		orced If Yes, Give Ye or Dates:	ar			Yes 2 X N				1	Lo	Specify:	Wh		
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mark ic even	의	19a. Informant's Na			Ι.	19	b. Mailing	Address (Stre							-	ip Code)
27 is				r, Jr. (Broth			North R									
Department of Health and In Important: If item 27 is ningury or other traumatic		20a Method of Dis		3 Removal f	rom State		of Dispositions of Disposit	tion (Name of ce er place)	emeter			ate	20c.	Location -	City or To	wn, Sta	te
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ician		23a. Part I. Enter the failure. List or	he disease, or	complications that on each line.	caused the	death. Do n	ot enter the	e mode of dying	, such	as cardia	ac or re	spiratory a	rrest, sh	ock, or hea	rt .	Approxi	mate Interv
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			1 - For State Registrar	State of Mary		artment of H rtificate of		Mental Hy	ygien Reg. N	1 to 10 to	6	19772
			1. Decedent's Name (First, Middle, La	st)				2. Date of D	eath			3. Time of Death
	Physici		JAMES EDWARD G	REEN				JUNE	16	•	ear	7:45 P
	/Medic Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of De			c. County of	_	7:45 P
	Zami		FREDERICK MEMO	RIAL HOSPI	TAL	FREDER	ICK		F	REDE	סד כיצ	•
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hi				. Birthpla	ace (State or Foreign
	Director		214-16-0899	1 X M 2□F	86 Yrs.	Months Days	Hours Mi	Sept.	13.	1919	Count	y) vland
	D D		Usual Residence of Decedent					, 50, 50				20110
	ylan		10a. State 10b. County	100	c. City, Town or Lo	ocation					10	d. Inside City Limits
	Ma 9-f	Ş	Maryland Frederic	k Po	oint of	Rocks						1 ☐ Yes 2 📉 No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of Wha	at Counti	ry?
	h wit		1752 Ballanger Cr	eek Pike		21777			USA			
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23s or 28e-1 ehow that the Medical Examinar must be confiled at	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin?			14. Race -		
9	after or its	I	1 Never Married 2 Married	1 ☐ Yes 2 X No	Í			into mican, etc.)			White, e	tc.
33	ours.	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ሺ No	Specify:			Specify:	Vhite	2
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215	hin .	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	d)	UIKIIIG				
2	filed withi Hygiene. other ther	5	7		Tracki	nan/Carpe	enter		Rai	1road		
2	e file al Hy oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Na	ame (First, Middle	e, Maide	n Sumame)		
<u>a</u>	should be nd Mental marked c	ဦ	John Henry Green				Daisv I	sabelle :	McCu	tcheor	1	
Maryland	2 should be filed and Mental Hygi is marked other raumatic event,		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street						Code)
	D = 2 T		Helen Irene Green	. wife	1752	Ballanger	Creek	Pike. Po	int	of Roc	rks.	MD 21777
ည်	f Hee		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of matory or other place	20)	Date		ocation - Cit		
2			1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Intellity at Itolii State			ł .	6/20/2	006	Dodest	- E 1	Rocks, MD
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licel									eral Home
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68760, 6	Physician Medical Examiner and physician and physician and physician and sthe partial flams; the partial flams; the partial flams; the partial flams in the	edicai Examiner	Immediate Čewše (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Husen nsequence of):	del in	fa-che.					Niset and Death
P.O. Box 68	Attending Physicien: The law requires that the death certificar death. cr death. ector: After this certificate hes been signed by the attending pl by the funeral director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of print 1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy	1			23d. Date of Month	,	day Year
σ.	s that hed b deta	by Pt	Part II. Other significant conditions	ontributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribu	te to the	cause of death?
Sp.	uires l signe		bastri atan.	Lhoni ubs	truche	polmara	¥	1 🗆	Yes 2	⊉ No 3[Probab	oly 4 Unknown
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<u></u>	n: The licate he		· · · · · · · · · · · · · · · · · · ·					1□ Yes	2 No		Yes 2	□ No
ξ	ysicien: 1 is certifical director, p	Be	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only	one)			
Division of Vital Records,	Phys this al dii	P.	1 Yes 2 No 27. Manner of Death	Inpatient	2 ER/Outpatien		4 Nursing	Home 5 ☐ Res			Specify)	
<u>_</u>	tending Ph leath. tor: After th the funeral	6	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c. Injur Wor		28d. Describe	how inju	ry occurred		
Si	Attendi death. ctor: A y the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 □ No					
≅	or At after of Direction by	E	4 Homicide determined		At home, farm, str ec <i>ify)</i>	eet, factory, office		28f. Location (City or To	'Street ai wn, State	nd Number o e)	r Aural F	Route Number,
	urs a	ပီ						1				
	Hosp 4 hours Lune ely fi	edicai	(Check only 2 Medical Exer	nysician: To the best of my niner: On the basis of exar	knowledge, death nination and/or inv	occurred at the ting	ne, date and place	e, and due to the	cause(s) and manne	r as stat	ed.
	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Med	Uney .	and manner stated.								1
	5 til 5 co		29b. Signature and title of certifier	1		29c. Licens				te signed (M		ay, Year)
			P V. (//	15		03	7178		6	-18-	06	
	. ^		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)						
	Y		J. Christopher Fl	Leming, 610 N	linth Ave	nue, Bru	nswick,	Maryland	2	1716-1	828	
	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's S	ignature	de la						
	a154*115*110	er –	1010 2 2 7 7 1111	11.1 10.40° A 10.00° A								

			1 = For State Registrar	State of Marylar		artmen rtificate			nd Me		ene 0 0	6 19773	
4	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last) RENA B • GREEN 4a. Facility Name (If not institution, give st		4b. City,	Town, or	Location of	N	2. Date of Death Month 1ay 27,	Day Year 2006 22:50 4c. County of Death			
*	Funeral Director		7107 Decatur Street 5. Social Security Number 579-24-9292 6. Sex 1□	7. Age (In yrs.	last birthday) Yrs.	Hya If Under Months	ttsv 1 Year Days	ille Il Under 24 Hours	4 Hrs. 8	B. Date of Birth (Month, Day, larch 14		George's Birthplace (State or Foreign Country) Washington, D	
Press.	ט	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		Oc. City, Town or Location Hyattsville							10d. Inside City Limits 1 □ Yes 2 □ No	
	leath with t	erai Dir	10e. Street and Number 7107 Decatur Stree	2. Was Decedent Ever in U	I.S. 13.1	Was Deced	0784 lent of Hi	spanic Origin	in? (Speci	fy Yes or No-	Og. Citizen of What Country? United States 14. Race - American Indian,		
9000	iours after d Iral', or iten L'Exeminan	d by Funerai	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	d 1 □ Yes 2 □ ANO If Yes, Give 1 Year or Dates:			efy Cubar 2 No	Specify:	Puèrto Ri	can, etc.)		White, etc. Black	
21215-(filed within 72 h Hygiene. Other than "nate	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 8 years	ation completed) College (1-4or 5+)	lite.	dent's Usua kind of wor DO NOT us House	rk done d se retired)	luring most o	of working	1	6b. Kind of Busin	,	
yland	should be file and Mental Hyg marked othe tumatic event,	Joshua Reynolds						Mir	nnie	Thompso			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Exprince from the confilled at Ance.		Joanne P. Green — 20a. Method of Disposition 1 © Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	Daughter 20b. F	2727 Place of Dispo	Fair1 sition (Nan	awn ne of ther place	Ave. S	SE #1	09 Wash	Oc. Location - Cit	DC 20019	
Balti	permit. Departminimporta		21. Sin ature of Funeral Service License	Lower !							neral Ho ington,	me, Inc. DC 20019	
8760,	The law requires that the death certificate be executed the law requires that the attending physician and sage 2 should be detached for use as the burial-transit	dical Examiner	23a. Part1 Enter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Congestive Due to (or as a consequence to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a)	Heart quence ol): erotic quence ol):	Fail	ure				J.,	Approximate Interval Batween Onset and Death	
.O. Box 6	it the death certifica by the attanding plached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pro					23d. Date of delivery Month Day			
Records, P.	w requires that been signed b should be deta	ρ	Part II. Other significant conditions control Anemia	ributing to death but not res	ulting in the u	nderlying ca	ause give	n in Part I.		1 🗆 Yes	2 □ No 3 [. A	
tal Rec		Be Completed	25. Was case referred to medical					26 Place o	of Death (24a. Was an autopsy perform 1 Yes 2	ed? prioi deat □No 1 □	re autopsy findings available r to completion of cause of th? Yes 2 No	
Division of Vital	ding Phys h. After this funeral di	P.	27. Manner of Death 1 Alatural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 Inpatie	ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r: 4 □ Nurs	ing Home	5 🗷 Resider	ce 6 Other (Specify)	
Divis	ital or Attenurs after deat rai Director: led in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	(y)					City or Town,	State)	or Rural Route Number,	
•	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier.	cian: To the best of my know: On whe basis of examina and manner stated.	idon and/or in	vestigation,	in my op License	inion, death	place, and occurred	at the time, dat	use(s) and manne e and place, and d. Date signed (N June 7,	due to the cause(s) Month, Day, Year)	
	Sta Registr		30. Name and address of person who com John N. Van Dam, N. 31. Date filed (Month, Day, Year) JUN 0 8 2006	npleted cause of death (Iter 1.D. 650 Penn 32. Registrar's Signa	ısylvan	ia Av	e.,	SE #37	70 Wa	ashingto	on, DC 20	0003	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien () 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June 8,2006 Gary **Physician** Lee Grove 12:15a4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13530 Mercersburg Road Spring, Clear Washington If Under 1 Year If Under 24 Hrs. An Date of Birth (Month, Day, Year)
Months Days Hours Min. Nov. 5, 194 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1⊈M 2□F 219-46-1232 58 Yrs. Director MD Usual Residence of Decedent death with the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at MD Washington Clear Spring, 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13530 Mercersburg Road 21722 U.S.A. Funera 12. Was Decedent Ever in U.S.
Armed Forces?

1X Yes 2 No
If Yes, Give Korean
Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mential Hygiene.
Important: if Item 27 is marked other than "natural", or Itan any njury or other traumetic event, the Marical Examinations. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Spec white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State Govt. Correctional Officer Elementary/Secondary (0-12) 12th grade College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George William Grove Sr. Mary Edna Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 13530 Mercersburg Rd.Clear Spring, MD 21722 Betty A. Grove 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 12, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, MD St.Paul Cemetery 2006 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O.BOX 310 Clear Spring, MD 21722 21. Signature of Funeral Service Licensee Tury succes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nevmunia Physician 2 weeks /Medical Due to (or as a consequence of): Examiner Due to (or as a cons., uence...): 10 minuty Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed ettending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2 autopsy performed/ 1 ☐ Yes 2 ☐ No 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home P 1 ☐ Yes 2 ☑ No funeral dir 5 Nesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Injury 1 Natural 5 ☐ Pending s efter death.
I Director: Afi 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide within 24 hours To the Funerel 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 6/9/2006 D0062647 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara A. Hneckter, 3H-15T MD 24 N. WalnutStreet. Hugerstown MD 21746 31. Date filed (Month) 32. gistrar's Signature State 09 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien®

			For State Registrar	State of Mary		artment of H <i>rtificate of</i>			ien e () () 6 og. No.	19775				
	Physicia	an	1. Decedent's Name (First, Middle, Kay Marlene	Gilbert				2. Date of Death Month June	Day Yea 9 200	3. Time of Death 7:00 A M				
	/Medic		Kay Marlene 4a. Facility Name (If not institution, s	4c. County of De										
	Examin	er	209 North Union Avenue Havre de Grace Harfor											
	Funeral				n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. B	irthplace (State or Foreign				
	Director		218-46-1435	¹□M ¾QX F 58	, 1947 M	laryland								
	and and	1	Usual Residence of Decedent 10a. State 10b. County	10	oc. City, Town or Lo	ocation				10d. Inside City Limits				
	Maryl	tor	MD Hari	ford	Havre	e de Grac	e			1X Yes 2 □ No				
	r 28a	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (zen of What Country?				
	th wit	ai D	209 North Union	Avenue		2107	8		U.S.A.					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene timportent: if item 27 is marked other than "natural", or items 23e or 28e-f show appring to other treumatic event, the Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 25€ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: Wh					
Maryland 21215-0036	2 hou	ted	15. Decedent's	Education	ring	16b. Kind of Busines	s/Industry							
215	thin 7 e.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire								
7	ygien ygien her th	Con	12	2	Trair	ning Coor	dinator/S		ivil Serv	ice				
and	ntal H ed otl	Be	17. Father's Name (First, Middle, La John Scott Shar					e (First, Middle, N nce Mari						
7	should nd Me mark matic	2	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street			City or Town, State	Zip Code)				
	nd 2 salth ar			Husband)	209	North Un	ion Ave.	Havre	de Grace	, MD 21078				
e,	ss 1 a		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other pla	ce)		20c. Location - City of					
altimore,	Page ment cent: if		1 S urial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		Harford M	iem. Gdns	6/12	/06 A	berdeen, 1	Maryland				
Balt	permit. Departitmportanny inj	P.A.												
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the	death. Do not en	er the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between				
	Pnysician	0.7	Immediate Cause (Final disease or condition	_a_Acute	myslora	d leuke	mia			onset and Death 18 mos.				
-	/Medical Examiner	Н	resulting in death)	Due to (or as a co	onsequande of):									
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):									
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events											
o	an an rial-tr	Еха	resulting in death) Last	Due to (or as a co	onsequence of):									
68760,	ficate be executed g physician and as the burial-transit	edicai		d										
P.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy	/		23d. Date of d Month	elivery Day Year				
	uires that t signed by d be deta	Completed by Ph	Part II. Other significant condition Cardio Vascular				ren in Part I.	23e. Did tob	N. 4	to the cause of death?				
Division of Vital Records,	w requir been si should	iete			01			24a. Was ar	24b, Were	autopsy findings available				
Re	The la e has age 2	dwo						autopsy perform 1 ☐ Yes 2	/ prior to	completion of cause of				
ta	an: T tificat tor, pa	Be C	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 th (Check only one		s 2 No				
<u></u>	nysici nis cen i direc	To B	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth	ler: 4 ☐ Nursing Ho	ome 5XReside	nce 6 Other (Sp	ecity)				
0 _	ng Pł kter tł ıneral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	Wor		28d. Describe hor	w injury occurred					
Sio	tendi Jeath. tor: A the fu	cati	2 Accident investiga 3 Suicide 6 Could no	t bo	At home form at		Yes 2 □No	294 Lanation /Ctr	ant and Number of	Donal Bayta Alumbay				
\leq	or At after of Direct in by	Certification:	4 Homicide determin		- At nome, tarm, sti Specify)	eet, factory, office		City or Town,	eet and Number or F State)	rurai Houte Number,				
_	To the Hospitei or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce		Physician: To the best of m kaminer: On the basis of ex and manner stated	amination and/or in									
	To the h within 2- To the I complet	Med	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mor					
}	->-0		Andat 676	ma MD		DIT	1912		June 9	2006				
	0		30. Name and address of person w	no completed cause of deat	h (Item 23a) (Type,	Print)				0 21231				
	3		JUDITH E. KARP M. 31. Date filed (Month, Day, Year)	n SKCCC @	bhns Hop	Kins 165	o Orleans	s St, CRA	5 Km 289,	Baltimore M				
	Sta Registi		31. Date filed (Month, Day, Year)	1 2 2006 Registr's	Signature	foot				2006 Baltimore M				

06-04127 Mary Alice Harper

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 15, 2006 0829 hrs Medical Examiner Mary Alice Harper 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 5803 Box Elder Court Frederick Frederick 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex **Funeral** Foreign Months Days Hours Min Director Country) M 2 X F 214-03-9157 Yrs 91 03/19/1915 N.Y. Usual Residence of Decedent any 10a, State 10c. City, Town or Location 10d Inside City Limits 28a-f show d at once. 1 Yes 2 X No MD Frederick Frederick hours after death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9 items 23a oust be notif 5803 Box Elder Court USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 3 X Widowed Divorced If Yes, Give Year Yes 2 No specify Specify White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r 21215-0036 Artist Art Industry 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Lawson L. Wright Verna M. Whitley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B James E. Harper Son 431 North Market Street Unit 2R Frederick MD21701 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify Smithsburg Crematory | 6/16/2006 | Smithsburg, MD 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service License Kas 106 East Church Street Frederick, MD 21701 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical a Exsanguination Death xaminer or condition resulting in death) Due to (or as a consequence of) b. Ruptured aortic dissection Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last tending physician and use as the burial - tran Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available page 2 should autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 Nο he Hospital or Attending Physician: Thin 24 hours after death he Funeral Director: After this certifica pletely filled in by the funeral director, px 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient ဥ 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 16, 2006 death (Item 23a) 30. Name and address of person who completed cause Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day Year) 2 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [State Registra Amend Item #5 Per FH C856 6/26/66/29 of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4-10AM DOR a 9001 SI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner owar Happital Loward Gli Veneral umbia C0 Age (In yrs. last birthday) 8. Date of Birth 09-12-1971 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 577-88-8333 6. Sex **Funeral** Months Days Hours 1 XM 2 ☐ F Director Wash. $_{
m DC}$ Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at Washington DC 1 ☐ Yes 2X No Direct 10f. Zip Code 20032 10g. Citizen of What Country? 10e. Street and Number USA 1830 Valley Terr. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify:Black Baltimore, Maryland 21215-0036 1 ☐ Yes X☐XNo Specify: þ 3 Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private Elementary/Secondary (0-12) 1 2 College (1-4or 5+) and Mental Hygiane. Finish Master 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Clarissa Hunter James Hamilton Jesse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1830 Valley Terr. SE Washington DC 20032 Clarissa Hunter/ Mother item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition permit. Pages Department of Important: If it any injury or once. Burial 2 Cremation 3 Removal from State 06/16/2005 Suitland, MD Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRonald Taylor II Funeral Ch. 10583 Middleport Lane, White Plains, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final i **Physician** 0 disease or condition resulting in death) /Medical Que to (or as a consequence of): Examiner 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner If or Attending Physicien: The law requires thet the death certificate be executed after death.

Director: After this certificate hes been signed by the attending physicien and it in by the funeral director, page 2 should be detached for use as the burial-transit Do Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 √ Yes 1√2 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2€XNo Mapatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital of within 24 hours at To the Funers! 12 Certifying Physician: To the best of my knowledge. Settle occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) echon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Carbre Lane Columbia, TIE K 32. Raistrar's Signature 31. Date liled (Month, Day, Year) State JUN 0 9 200\$ Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 30, 2006 2:25 P.M **Brooks** Beatrice Hunter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Prince Georges** Clinton Southern Maryland Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, May 3, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🗙 F 86 Virginia 579-36-7115 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show Examiner must be notified at 1XYes 2 □ No District of Columbia Washington Director 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 20001 United States Bates Street, N. W. 70-A or items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after to Department of Heelih and Mentel Hygiene. important: If item 27 is marked other then "natural", or item any injury or other traumatic event, the Medical Examinations. 1 □Yes 2 No 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give ** Year or Dates: 3 ¥ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry McLaughlin National Elementary/Secondary (0-12) College (1-4or 5+) Bank Chef 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Meredith Myrtle (unknown) Jacob **Brooks** ၉ 19a. Informant's Name/Relationship (Type, Print (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bates Street, N.W.; Washington, D. C. 20001 Carolyn M. Hunter Horton 70-A 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 9, 2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State National Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 21. Signature of Funeral Service R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) My ocardier Pnysician /Medical Due to (or as a consequence of) Examiner S ventially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (o: as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed and buriai-trar resulting in death) Last Due to (or as a consequence of): Box 68760, attending physiclen Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 TYes 2 J No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificete 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death To the Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. whe of certifier 29d. Date signed (Month, Day, Year) 29b. Signature any 29c. License number Muy 31 10055120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1325 Jonteon avenue St Sink 310 Washing by DC 20032 31. Date filed (Month, Day, Year) State Registrar JUN 0 8 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 2006 /Medical Audrey Margaret Hickey June 7:59 A 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House
5. Social Security Number 6. Sex 7. Age (In yr Rockville
Under 1 Year | ff Under 24 Hrs.
onths | Days | Hours | Min. Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Months Director 215-12-8853 84 Maryland Jan. 12, 1922 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location ai Hygiene. I other then "naturel", or items 23s or 28s-f show event, the Medical Examiner must be notified at 10d. fnside City Limits 1 ☐ Yes 21 No Directo Florida Pasco Hudson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12218 Fox Chase Drive death by Funeral Unit El 34669 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ②No ff Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Iter any Injury or other traumatic event, the Madical Examina Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Nidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be မ William J. Smith Barbara E. Spiegel 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gemma M. Weiblinger Daughter 15503 Clayburn Drive Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery June 9,2006 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, MD 20901 any 420 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** <u>Colon Cancer</u> years /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical use as ed by the attending detached for use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 🔯 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice ္ 1 ☐ Yes 2 TNo 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. tnjury at Work? Certification: 28d. Describe how injury occurred 1 XNaturaf 5 Pending investigation s after death. 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital o within 24 hours at To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who in e 42452 D June 7, 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Chitra Rajagopal, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20850

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 8

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2006

Registrar's Signature

		•	For State Registrar	State of Ma	arylan	-	rtment o			Ment		jiene •g. No.	200	6 1	9781
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		1	For State Registrar	State of Ma	ryland		artmen rtificat				ental Hy	giene Reg. No.	006	19	782
			1. Decedent's Name (First, Middle, Last)								2. Date of De	Dav	Year	3. Time	
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.O. Box 68	death certifica e attending pl ed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 🗌 Fetai	death 3	⊒Ectopic p					23d.	Date of del	livery Day	Year
s, P	uires that signed by Id be deta	by	Part II. Other significant conditions co	ntributing to death bu	it not resu	ilting in the u	inderlying o	ause giv	en in Part I	l. 		tobacco use			death?]Unknown
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Vital		O	25. Was case referred to medical						26. Place	e of Death	(Check only				
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0			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		28c. Injun Work			28d. Describe	how injury or	curred		
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Division	l or At after d Direct I in by	Certification;	4 Homicide determined	28e. Place of Injubulding, etc			reet, factor	у, опісе			28f. Location City or To	wn, State)	JIIIDEI OI AL	urai Houle ivu	mber,
	Hospita 4 hours Funerel ely filled	Medical Ce		rsician: To the best of iner: On the basis of and manner sta	examinat										(s)
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	⊢ <i>≶</i> ⊢ Ö		V KaKosh	MONON	CA	MI)	D	20	10	8	6	1171	06	
	î		30. Name and address of person who of	ompleted cause of de	eath (Item	23a) (Type	Print)								
	Ų		Rakesh Arora MD	, 14300 Ga	llant	t Fox	Lane,	Boy	vie, N	Mary]	Land 20	715			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2. Registra	ar's Signa	eure .	ule								

Please Type or Print in Black Indelible Ink

aren Nobelt Ja		State of Maryland / Department of Health and Menta 1. For State Certificate of Death Registrar		ZUU(teg. No.	19/8				
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	Date of Dea Month	ath Day Year	3. Time of Death				
edical Exami	ner	DURELL ROBERT JACKSON 4a. Facility Name (if not institution, give street and number) 14b. City, Town, or Location of I	May 9, 20	4c. County of Death	0600 hrs				
,		Roxbury Correctional Institute Hagerstown		Washington					
Funeral Director		5. Social Security Number 2 16 - 48 - 5529 1 1 1 M 2 F 58 Yrs. Frage (In yrs. last birthday) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Min.	rth(MM/DD/YYYY) 9 Bir Foreig Co					
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits				
* .	ŏ	MD CAROLINE DENTON			1XXYes 2 No				
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menla Hygievier han "natural", or items 23a or 28a-f she 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 10f. Zip Code 210 NORTH 5th STREET 21629		10g. Citizen of What Coul USA	ntry?				
leath wit r items 2	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		14. Race - Ameri White, etc.	can Indian, Black,				
s after or ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: BLA					
72 hour n "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kir during most of working life. DO NOT us		16b. Kind of Business/I	ndustry				
5-0036 iled within 7/ Hygiene I other than	dmo	3yrs LABOR		UNKNOW					
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ID 2121 t should be fit and Mental I is marked natic event,	P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number TOVOLIA ANN WAYMAN 23599 RANDALL S							
= p = e =		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or					
More, Pages I and rent of Healt internal internal		1 Burial 2 Cremation 3 Removal from State CAPITOL CREMATORY 4 Donation 5 gither specify:	5-15-06	DOVER DE	LAWARE				
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr	- 1	21 gnature of Funerry Service Licens, e 22. Name and Address of Facility	HOME 20	O N OUDDN	CM DOVED				
Physician	-/	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.			Approximate Interval				
/Medical Examiner	1	Immediate Cause (Final disease a Hypertensive atherosclerotic cardiovascula	ar disease		Between Onset and Death				
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
	iner	if any leading to immediate							
ted Insit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.							
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760, ficate be g physici s the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p	arognapo.	23d. Date of delivery	Day Year				
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 burs after death. The Funeral Direct death. The Funeral Direct After this certificate has been signed by the attending physician and appletely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Medical	past 12 months? 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown	neghancy	IVIOLITY E	ray Teal				
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Di To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one) 2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one)							
To with	Me	29b. Signature and title of certifier 29c. License number							
		O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)		May 10, 2006					
		Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	MD 21201						
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Red krar's Signature							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** June 3, 2006 4:10 P Jean H. Jones /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Mitchellville Villa Rosa Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 28, 1908 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🖾 F VA Yrs. 98 Director 212-20-2237 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County 28a-f ehow , or itema 23a or 28a-f ehor ar direr nust be nutified at 1 ☑ Yes 2 ☐ No Washington Directo DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20002 U.S.A. #501 1400 Florida Ave. NE Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ the Madical Exar 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) Food Caterer permit. Peges 1 and 2 should be filed v Depertment of Health and Mental Hygiel Important: If item 27 is marked other it any injury or other traumatic event, IIIa once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lavinia Triplett Edward W. Hansborough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1708 Loft Way, Silver Spring, MD 20904 J.B. Withers, Jr.- Grt. Neph. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 06/9/2006 Frentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End stage renal disease vears /Medical Due to (or as a consequence of): Examiner Hypertensive cardiovascular disease years Sequentiary list conuncts, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, ettending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Dav in the past 12 months? ğ 4☐ Pregnant at time of death 5 Other (specify) sete has been signed by the page 2 should be deteched 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificete the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours aftar deal Funeral Director 6 ☐ Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) δ 4 ☐ Homicide 29a, Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 010 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Lane, Suite 222, Bowie, MD 20715 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 8 2008 Registrar

	ñ,	1	For State Registrar	State	of Marylar		rtment of H tificate of L			eg. No.	19785			
3	Dhuriais		1. Decedent's Name (First, Midd	die, Last)					2. Date of Deat Month	Day Year	3. Time of Death			
	Physicia /Medic	al -	Vesta	С	Jones					3, 2006	9:23 A ^M			
	Examin	er	4a. Facility Name (If not instituti				4b. City, Town, or		ath	4c. County of Death				
			Washington Ad 5. Social Security Number	Ventist Ho	7. Age (In yrs.	last hirthday)	Takoma If Under 1 Year	If Under 24 Hr	rs. 8. Date of Birth	Montgomer 9. Birth	y place (State or Foreign			
	Funeral Director		579-48-4091	1 M 2 X F	76	Yrs.	Months Days	Hours Min	n. (Month, Day,	Year) Con 1930 Vir	intry)			
		b	Usual Residence of Decedent							, = 500				
	yland		10a. State 10b. Coun	ty	10c. Ci	ty, Town or Lo	cation			10d. Inside City Lin 1 ∑ Yes 2 □				
	e Ma	cto	MD Mont	gomery		Silver	Spring							
	± 26 €	Director	10e. Street and Number				10f. Zip Code		1	log. Citizen of What Co	intry?			
	ath w	ral	1605 Overlook		cedent Ever in U	10 112 1	20903	lienanic Origin?	(Specify Yes or No-	USA 14. Race - Amer	ican Indian.			
36	72 hours after death with the Maryland natural, or Itams 23a or 28a-f show Jeal Examiner must be undiffed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ★ Widowed 4 □ Divorce	Armed F arried 1 ☐ Yes	Forces? 2 📉 No Bive		f Yes, specify Cuba 1 ☐ Yes 2 ▼ No	Specify:	(Specify Yes or No- erto Rican, etc.)	Black, White Specify: B1	, etc.			
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٦	be filed htal Hygi ed other event,	ВеС	17. Father's Name (First, Middle	e, Last)				18. Mother's N	lame (First, Middle,	Maiden Sumame)				
<u>a</u>	should be nd Mental s marked o umatic eve	ည	Charlie Age	e					Garrett					
40	2 sho and Is ma		19a. Informant's Name/Relatio							r, City or Town, State, Z				
	ss 1 and 2 should b of Heelth and Ment Item 27 Is marked r other traumatic e		Wanda Johnson/	Daughter	20h		Kerwood	Road, S	Silver Spr	20c. Location - City or	20904 Fown, State			
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other		n State	cemetery, crei orge Wa	natory or other place shington	Cem.Jun	e 9,2006	Adelphi, l	AD .			
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			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that ist only one cause or	t caused the dea n each line.	th. Do not ent	ter the mode of dyin	ng, such as card	iac or respiratory arr	rest,	Approximate Interval Between Onset and Death			
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n C	ng P	on:	27. Manner of Death 1 Natural 5 □ Pen	idirig	te of Injury onth, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe h	now injury occurred				
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 X Certifier (Check only one)	cal Examiner: On the	the best of my kr basis of examir anner/stated.	nowledge, dea nation and/or in	th occurred at the ti	ime, date and pla opinion, death o	ace, and due to the occurred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)			
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2	TO TO DE DE LA COL		30. Name and address of pass Richard A. Wil	son who completed can son, Jr. 1	MD 106	Irving	Print) Street,	11903	5, Washin	6/5/00	h, Day, Year)			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 3, 2006 8:40 P Betty Ellen Johnson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year, 5-13-1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2XX Yrs. 78 Kansas 548-38-8857 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int; if Item 27 is marked other than "natural", or items 23s or 28s-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23s or 28s-f shot traumatic svent, the Modical Examinar must be nutlified at 1 Yes 2 No Anne Arundel Edgewater **Funeral Director** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21037 122 Valley View Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Home** Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frances Brayfield Harry William Marler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 122 Valley View Ave., Edgewater, MD 21037 Health Item 27 other tra Theron H. Johnson/ Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ξ 5 Department of Important; if any injury or once. Crownsville, MD MD Veterans Cemetery | 6-8-06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Molma Ull 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HU 10 Physician Immont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mell. 1 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? mevaio 2 No 1 TYes 1 Yes 2 TNO Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 HO 2 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerei Director: After thi
completely tilled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ath (Item 23a) (Type, Print) 30. Name # d addre 116 31. Date filed (Month, Day, Year) egistrar's Signature State JUN 0 7 2006 Registrar

		_	For Stete Registrar	State of M	1arylan		artment tificate				F	Reg. No.	2006	19	787
	Physicia	an	1. Decedent's Name (First, Middle, Last Patricia Ames	lones							P. Date of Dea Month Lune	ath Day २	Yeer 2006	3. Time o	
	/Medic Examin		4a. Facility Name (If not institution, give								une	4c. (County of Death		<u></u>
	e xamm		23270 Holly Park I)rive				ston				Ca	roline		
	Funeral Director		5. Social Security Number 6. Se 222-26-1007 10	TM ofM∈	ge (In yrs. 4	last birthday) Yrs.	tf Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day Luly 22	/. Year)	9. Birth Cou	place (State intry) PA	or Foreign
	Ba-f ehow	ector	10a. State 10b. County MD Caroline	ocation						10d. Inside City Limits 1 ☐ Yes 2 ☐ Yo Citizen of What Country?					
	3a or 2		10e. Street and Number 23270 Holly Park I	rive			10f. Zip	655				_	en of What Col ISA	intry (
336	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural", or iteme 23s or 28s-f show event, the Modical Examinar most be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces 1 Yes 2 If Yes, Give	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu				in? (Speci Puerto Ri	17 (Specify Yes or No- Puerto Rican, etc.) 14. Race - Ar Black, WI Specify:			, etc.		
21215-0036	within 72 hou ane. then "natura	Completed	15. Decedent's Ed (Specify only highest grad	ucation le completed) Cotlege (1-4o	r 5+)	16a. Deced (Give life. L 7each	kind of wor DO NOT us	it Occupa rk done d se retired)	tion uring most	of working		Rub		f Business/Industry	
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Mar	ind 2 sho eith and 27 is my er traum		19a. Informant's Name/Relationship (T) Wesley Ames Schuc			1	-				Route Numbe	•	Town, State, Z.	ip Code)	
altimore,	permit. Pages 1 and 2 should b Department of Heelth and Menta important: if Item 27 is marked any injury or other traumetic e <u>pnce</u> .		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,		20b. F	Place of Dispo semetery, crem itol C	sition (Nam natory or or nemut	ne of ther place ONY	6.	Da /5/20			eation-City or 1 N, Dela		
Balti	permit. Depertri Importa any inju		21. Signature of Funeral Service Licent	? (Nov.	Le_	22 Mc	. Name an OORE FL	d Addres	s of Facility Home,	PA, 1	2S. Seco	ondSt.	, Denton	, MD 210	529
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the disease or condition resulting in death)	a. Ova:	ed the deat line.	\vee	0		, such as o		respiratory ar	rest,		Approxima Interval Be Onset and	tween
8760,	ate be executed hysician and the buriel-transit	Ical Examiner													
.O. Box 68	Attending Physician: The law requires that the death certificate be executed rideath. cleath. ector: After this certificate has been signed by the ettending physician and better this certificate as been signed by the tuneral director, page 2 should be detached for use as the buriel-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	il death 3□	Ectopic pr Other (sp					2	3d. Date of deline Month		Year
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of Vital	certifi	Be c	25. Was case referred to medicat examiner? 1 Yes 2 No	Hospital:		IED/O		Othe	-		Check only o		5 0		
n of	ding Physician: The Ih. h. After this certificete ha funeral director, page	lon: To	27. Manner of Death 1 Natural 5 ☐ Pending			28b. Time of Injury	2	8c. Injury Work	at	28	d. Describe h		Other (Spec	iry)	
Division		ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	njury - At h etc. <i>(Specil</i>	ome, farm, str fy)	M eet, factory		/es 2□N		of. Location (S City or Tow		l Number or Ru	ral Route Nur	nber,
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	To the within To the complex c	Me	29b. Signature and title of certifier &	Wes	MY	>	D 290	License		6			signed (Month		
			30. Name and address of person who co	completed cause of	f death (tter	m 23a) (Type,	Print)	- N	+ 0	St	De	1 it	5-0 Ton	MS	2
	Sta Regist		31. Date filed (Month, Day, Year)	32. Risgi	strar's Signa	ature	Joseph)						.,	-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMENT TTEM#26 PER VERB, C856 6/22/06 WS

State of Maryland / Department of Health and Mental Hygiene) Reg. No. U 0 6 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5:10 A. м 19, 2006 June Gladys G. Kirchoff /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Potomac Montgomery Manor Care Potomac | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 1 F Yrs. 94 19, 1911 Washington, D.C Director 577**~**34~8731 Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City. Town or Location 10a. State r than "natural", or Items 23a or 28a-f ahow the Mcdrai Examinar must be notified at 1 X Yes 2 □ No Director D.C. None Washington the 10g. Citizen ol What Country? 10e. Street and Number 10f. Zip Code 49th Street, N.W. 20007 U.S.A 2205 death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene Important: If them 27 is marked other than "natural", or Iten any Injury or other traumatic event. In Medical Examinations. 1 ☐ Yes 2 ☑ No tl Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White δ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph W. Gregory Carrie M. Springmann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2205 49th St. N.W.
Washington D.C. 20007 19a. Informant's Name/Relationship (Type, Print) Garry T. Swanson/ Nephew 20a. Method ol Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gate of Heaven JUNE 21, or other place) 1 Donation 2 □ Cremation 3 □ Removat Irom State 4 □ Donation 5 □ Other (Special) 2006 Silver Spring, Md. Cemetery 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Lioer see 2222 Wisconsin Ave. N.W. Washington, D.C. 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UROSEPSIS /Medical Due to (or as a consequence of): Examiner SEIZURES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed HYPERTENSION Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical ATRIAL FIBRILLATION IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown HYPOTHYROIDISM page 2 should Be Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No this certificate has 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) in by t 4 - Homicide filled the Hospital 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Baltimore, Maryland 21215-0036

State Registrar

Kirti Vohra, M.D 31. Date liled (Month, Day, Year)

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

D-20274

June 19, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7710 Bradley Blvd. Bethesda, Md. 20817

JUN 2 2 2006

		1	For State Registrar		State o	f Marylan		artment rtificate			and M		Reg. N	/ 11	06	19789
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5-0036 lled within 72 Hygiene I other than '	Completed		4+	FI	NANC)	AL AN	IALY	ST			GOVER	NME	ΝΤ	
5-0 iled w Hygic I othe		17. Father's Name (First, Middle									iden Surname)		
21215-0036 uld be filed within 72 Mental Hygiene marked other than c event, the Medical	a	HAROLD A. KING 19a. Informant's Name/Relations		110h	Mailing A	ddroes (S		RUBY	SIMMO		er, City or Tow	- Ctata	Zin Code)	
MD 21215-0036 and 2 should be filed within 72 feath and Mental Hygiene tem 27 is marked other than "traumatic event, the Medical	٩	HAROLD A. KING									E, MARYI			
imore, MD Pages I and 2 shoment of Health and tant: If item 27 is or other traumati	HAROLD A. KING/FATHER 1522 BRADY COURT MITCHELLVILL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)										20c. Location -			
2 s de = 2		1 X Burial 2 Cremation		cremato HARMON			v	6	/8/2006	,	LANDO	/FD	ΜΛΡΥΤΛ	MD
Baltimo permit Page Department of Important: injury or oth		4 Donation 5 Other S 21. Signature of Rune at Source		HARMON							INS FU	-		
Baltil permit Departm Importa injury o											R,MARY			
Physician	T	23a. Part I. Enter the disease, or failure. List only one cause		death. Do not	enter the	mode of dy	ring, suc	ch as cardia	ic or respirato	ry arrest	, shock, or he	art		ate Interval Onset and
/Medical Examiner		Immediate Cause (Final disease		Vounds										eath
Examiner		or condition resulting in death)	Due to (or as a consequ	ence of):										
	<u>,</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ence of):										
	Ē	cause Enter Underlying Cause (Disease or injury that initiated												_
ed	Examiner	events resulting in death) Last	Due to (or as a consequ	ence of):										
xecuted n and l - transit	g	UNPENDED	dAMENDED											
ox 68760, sath certificate be ex attending physician for use as the burial.	ledi	IF FEMALE:	23c. If yes, outcome	of prognancy							23d Date of	dolivos		···
Box 68760, c death certificate be the attending physic of for use as the but	an/Medi	23b. Was decedent pregnant in t past 12 months?	he 1 Live birth	or pregnancy 2	Fetal	death	3	Ectopic pre	gnancy		Month		ay	Year
ox 6 ath cer attendi	<u> </u>	1 Yes 2 No 9 ✔ Un	4 Pregnant at tim	e of death 5	Othe	r (Specify)								
The dest	Phy	Part II. Other significant condi	S Olikilowii	it not resulting	in the un	erlying car	ise aive	en in Part I	23e	Did toba	acco use contr	bute to	the cause of	death?
P.O.	<u>a</u>	Ture in Construction	and contributing to dod in bo	at Hot Fooditing		aoriy irig odd	ace give	, , , , , , , , , , , , , , , , , , ,			2 V No 3		40000	
ords, v require s been sig	Completed								24a.	Was an	24b. \	Vere au	topsy finding	s available
taw re has by 2 sho	힐								- _	autopsy performe	ed?	rior to d leath?	ompletion of	cause of
tal Rection: The continuate lector, page	ខ្ញ	25. Was case referred to medical 26.Place of Death (Check only one)									✓ Ye	s 2	No	
ician:	Be	25. Was case referred to medica examiner?	Hospital: 1 Inpatient	2 FR/Ou	tpatient			hor:	rsing Home	5 De	esidence 6	Other	Scana	
of Viting Physic After this	2	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury	28b T	me of Inju			at Work?			w injury occurr		. Scelle	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should let a selection the funeral director.	ion	1 Natural	FOUND: Day Year			1[Yes	2 V No	Subject					
r Atte	ficat		Jun 2, 2006 28e. Place of Injury	1718 y - At home, fai		factory, offi	ice build	ding, etc.			eet and Numb	er or Ru	ral Route Nu	mber, City
Div ital or urs aft	Certification:		ermined (Specify) Single	e Family						wn, Stat Campu	^{e)} IS Way Soi	uth, U	per Maril	oro, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	al C	29a. Certifier 1 Certifying P	Physician: To the best of my ki	nowledge, dea	h occurre	d at the time	e, date	and place, a	and due to the	cause(s	s) and manner	as star	ed	
To the Ho within 24 To the Fu completel	edical	one) 2 Medical Exa	aminer:On the basis of examin and manner stated	ation and/or in	vestigatio	n, in my opi	inion, de	eath occurre	ed at the time,	date an	d place, and d	ue to th	e cause(s)	
7	ğ	29b. Signature and title of certifi	er A.	,			cense n				29d Date sign		nth, Day, Year	r)
6/)	4	W. It			°	.C.M.	E.		`	June 3, 20	J6		
015	*	30. Name and address of person			1 D	Chron	Dalilio		21204					
(1/100)		Jack Titus MD. De	puty Chief Medical Exa	miner 11	renn	Sueet, I	Daitin	iore, MD	21201					

State 31. Date filed (Month, Day, Year)
Registrar
JUN 0-7-2006 DHMH 17 Rev 1/2001 OCME 2006

			For State Registrer	State of N	/larylan		artment			and M		giene Reg. No.		5 1979	-
			Decedent's Name (First, Middle,	Last)							2. Date of De	ath		3. Time of Death	
	Physicia			THOMAS	Μ.	KENG	LA				June	2 , Day	2006	11:10 4	Y m
	/Medic Examin	_	4a. Facility Name (If not institution,					Town, or	Location o				County of De		
			John Hopk	ins Hospi	tal				nore						
	Funeral			6. Sex 7. / 1.25 M 2. □ F	Age (In yrs. 56	last birthday) Yrs.	If Under Months	1 Year Days	Hours	24 Hrs. Min.	8. Date of Bir (Month, Da OCT • I	th Y Year)	4 Q 9. B	irthplace (State or Foreig Country) Maryland	gn
	Director	-	213-54-8393 Usual Residence of Decedent		30	113.					000.1	± , ⊥ ⊃	43	Maryranu	
	land w	ŀ	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limit	ts
	Mary	ģ	MD Monto	gomery		Rockv:	ille							1 🗗 ¥es 2 🗆 N	lo
	h the	Director	10e. Street and Number				10f. Zip						zen of What (
	within 72 hours after deeth with the Maryland ene. Than "natural", or fleme 23a or 28e-f ehow he Medical Examiner must be notified at	aio	9905 Sunset	Drive			1	2085					U.S.A		
	eme erme	Funerai	11. Marital Status	12. Was Deceder Armed Force ad 1 \(\text{Yes} \) 2 [nt Ever in U \$?	.S. 13.	Was Deced f Yes, spec	lent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe ı, Puerto l	cify Yes or No Rican, etc.))-	14. Race - An Black, Wh	nerican Indian, nite, etc.	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 [If Yes, Give Year or Date:			1 ☐ Yes 2	2 ⅓ No	Specify:				Specify: W	hite	
8	tural	ed t	15. Decedent's			16a. Deced	dent's Usua	I Occupa	ition				nd of Busines		
7	n na 72	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c	nr 5+1	life.	kind of wor DO NOT us	e retired)	luring most)	t of workii	ng	1	-	ry County	r
ด	d with giene grene	Completed	12th	Conlege (1 1		Cus	stodi	Lan				Pub	lic S	chools	
ਰ	2 should be filed within 72 hours after deeth with the Marylan and Memiral hygiene. I wanted that I hygiene is marked other than "natural", or lieme 23s or 28e-f show is marked other than "natural", or lieme 23s or 28e-f show is marked other than Medical Examinar must be notified at	Be (17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)		
<u> </u>	Ment Ment arked	ဥ	Lewis R.	Kengla							y Cos				
Mar	2 sh and ie m	6 4	19a. Informant's Name/Relationsh		L	1	-				I Route Numb	-			
e,	Heart The T		Kimberly Keng	gia-Daugn							e rre			MD 21703 or Town, State	
סר	S S S S S S S S S S S S S S S S S S S		1 ☐ Burial 2 ☐ Cremation	3 □Removal from Sta		Place of Dispo cemetery, crer etro I				6/8				ria, VA	
Baltimore,	ortme rtent		4 Donation 5 Other (Sp		1	22	Name an	Svc d Addres	S	v Sne	owden			Home, PA	
Ba	permit. Pages 1 end 2 should be Department of Health and Menta Importent: if tem 27 ie marked any injury or other treumatic ev ange.	_	1 sons	UK	1/0	/	246 N	1. W	ashi	ngt	on St	Roc	kvill	e, MD2085	0
			23a. Part1. Enter the disease, or	complications that caus	ed the deal	th. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between	
	Physician		shock, or heart fallure. List of Immediate Cause (Final	only one cause on each	0									Onset and Death	
3	/Medical		disease or condition resulting in death)	a Due to (or	as a consec	uence of):	3							acy	
	Examiner		Sequentially list conditions	b											
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury	Due to (or	as a consec	quence of):									
	and and trans	каш	that initiated events resulting in death) Last	c. Due to (or	as a consec	ruence of):									
8760,	ate be executed hysician and the burial-transit	ical E				(
587		edic		d											
Box 6	death certifica e attending ph ad for use as t	Ň	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom]Ectopic pr						23d. Date of d	elivery	
œ.	es that the death certific igned by the attending p be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnani 9☐Unknowr	at time of o		Other (sp						Month	Day Year	
P.O.	at the	ج	9 Unknown					-			00.00				_
	The law requires that the see has been signed by th page 2 should be detache	5	Part II. Other significant condition				nderlying c	ause give	en in Paπ I.	•		Yes 2		to the cause of death? Probably 4 Onknow	wn
Oro	w require been sij should t	Completed	rigeloay	splestic s	770	20016							1		_
3ec	nelaw hast ge 2 s	mpi						-			24a. Was		prior to death	autopsy findings availab o completion of cause of ?	i e
al	n: Th ficete rr, pag		OF Mes case referred to medical								1 ☐ Yes	2 No	1 🗆 Yı		
₹	Physician: r this certificated director,	o Be	25. Was case referred to medical examiner? 1 Yes	Hospital:	atient 2] ER/Outpatier	nt 3 DC	Othe			n <i>(Check only</i> me 5 ☐ Res		S □Other /S/	agrifu)	
of	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of I		28b. Time o		8c. Injury			28d. Describe			occuy)	
<u>io</u>	Attending ir death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investig		Day 1 Gai/	Injury	м		Yes 2 ☐	No					
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of	Injury - At h	nome, farm, sti	reet, factory	, office		:	28f. Location (City or To			Rural Route Number,	
ō	ital or ris aft														
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Medical	29a. Certifier 12 Certifying (Check only 2 Medical E	g Physicien: To the be Examiner: On the basi	s of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	ne, date an pinion, dea	id place, a th occurr	and due to the ed at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner	Stated.		290	. License	number			29d. Dat	e signed (Mo	nth, Day, Year)	
	£3£8		> Mil Ast	- Phys	Teres				0556	94				, 2006	
	Ψ		30. Name and address of person v	who completed cause of	of death (Ite	m 23a) (Type.	Print)								
			Α	17 HUR		00 RH	108	(Olze	Υ,	MD	208	32		
	Sta		31. Date filed (Month, Day, Year)		istrar's Sign	ature	(W								
	Regist	rar	JUN 8	2006	2150	15. 16	CARL								

		3 .	For State Registrar	State of Marylan		ment of F ficate of		Mental Hy	rgiene 00	19792
			Decedent's Name (First, Middle, Last)				7 44 0	2. Date of De	eath	3. Time of Death
	Physici /Medic	_	CHARLES	NEAL		LE	WIS	MAY	29 200 Yeer	6 320PM
<i>)</i>	Examin Funeral Director		4a. Facility Name (It not institution, give s 5. Social Security Number 217-42-2008	Girs Hosp	fal last birthday)	b. City, Town, c	If Under 24 Hrs Hours Min	8. Days of Bi	4c. County of December 19. Bin 1941 Wa	onth ath athplace (State or Foreign country) Shington, DC
	D >		Usual Residence of Decedent 10a, State 10b. County	10c Cit	y, Town or Locat	tion				10d. Inside City Limits
	faryla	ŏ				r Sprin	œ			1 ☐ Yes 🏂 ☐ No
	the N	Director	Maryland Montgome 10e. Street and Number	Гу	21106	10f. Zip Code	·8		10g. Citizen of What C	Country?
	h with		3231 South Leisur	e World Blvd		209	06	Ur	nited State	s of America
21215-0036	i 72 hours after death with the Maryland "netural", or iteme 23e or 28e-f ehow idical Examiter must be myllified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Agned Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1962-	If Y	s Decedent of Hes, specify Cub	Hispanic Origin? (lan, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	Black, Wh	
20	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give kin	it's Usual Occup of of work done	during most of wo	orking	16b. Kind of Busines	s/Industry
2	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO	NOT use retire Metal	d)	,	Recyclin	α
	Hygie ther t int, ith	o C e	17. Father's Name (First, Middle, Last)		БСГАР	Metal		ame (First, Middle	a, Maiden Sumame)	8
lan	id be entai ked o ic eve	To Be	Robert Lewis				Lilli	an Blanc	che Pollock	
Maryland	s 1 end 2 should ! Health and Mer Item 27 ie marke other traumatic		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailing	Address (Street	and Number or F	Rural Route Numb	per, City or Town, State,	Zip Code)
-	of Health a		Jill Lewis - Wife				isure Wo			pring, MD 209
Baltimore	0 0 = 5V		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Re	amoval from State	Place of Dispositi cemetery, cremat	ory or other pla		Date 5/09/06	20c. Location - City o	r Town, State , Maryland
ţ			4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun and Service License		Lincol					
Bal	permit. Departrimportri		21. Signature of fur his same License	•	118	00 New	Hampshir	e Ave,	ldi Funeral Silver Spri	ng, MD 20904
	Physician /Medical Examiner		23a. Párt: Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ations that caused the deate e cause on each line. Due to (or as a consection of the consection of th	IORG Juence of):	AN S HOCK	ng, such as cardia		LURE	Approximate Interval Between Onset and Death IO DAYS
,8760,	cate be executed physicien and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	CARINI Due to (or as a consequence)	OMY	OPAT	rty			IO YEARS
.O. Box 6	death certifi e ettending d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	il death 3 □Ed	ctopic pregnanc other (specify)	у		23d. Date of do	elivery Day Year
a	signed be de	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the unde	erlying cause gr	ven in Part I.		tobacco use contribute Yes 2 No 3 F	to the cause of death? Probably 4 Dunknown
I Records,		Completed						24a. Was auto perf 1 ☐ Yes	ormed death?	autopsy findings available completion of cause of
Vital	Physicien: T this certificet al director, pa	Be (25. Was case referred to medical examiner?	nental:		104		eath (Check only	опе)	
of	ding After funer	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 V npatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo			idence 6 Other (Sp how injury occurred	ecity)
Division	el or Attending s after death. il Director: After id in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street fy)	t, factory, office			(Street and Number or F wn, State)	Rural Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Medicai (ician: To the best of my known are: On the basis of examination and manner stated.						
	To the To the Comp	Ž	29b. Signature and title of certifier	1 /2 2		29c. Licen:	se number		29d. Date signed (Mor	nth, Day, Year)
	17/		yers	AT V	10	KE	5-00	10	MAY, 2	4,2006
			30. Name and address of person who co				OLFE	STREET	BALTIMOI	RE, MD 21287
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signa		E)				

			For State Registrar	State of Ma		•		t of H	ealth a		ental Hyg	iene ₂	006	19793
	Physici	an	Decedent's Name (First, Middle, Las HAE OK LEE	1)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al		atomat and numbers			4h Cihi	Tour or	Location o	f Dooth	June	5,	2006 ounty of Death	10:40 P M
	Examin	er	4a. Facility Name (If not institution, give Casey House	street and number)			1	kvi1		Death			ntgome	
	Funeral Director		5. Social Security Number 6. Se	x 7. Age	(In yrs. 52	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day Nov . 22		_	place (State or Foreign intry) th Korea
	P.		Usual Residence of Decedent		10a Cit	y, Town or Lo	nation							10d. Inside City Limits
	show	ă	Md. 10b. County Md. Montgom	orv		mantow								1 ☐ Yes 2 X No
	the N 28a-1 notifi	rect	10e. Street and Number			marred	10f. Zip	Code			1	0g. Citizer	n of What Cou	intry?
	h with	O I E	20814 Gaelic Cou	rt			2	0874				Unit	ed Stat	tes
	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U	.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-f show the Madical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖔 N If Yes, Give Year or Dates:	0		1 ☐ Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,		Sp	pecify: As:	
5-0	72 ho	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa nk done d	ition <i>Juring</i> most	of worki	ng	16b. Kind	of Business/I	ndustry
121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Homen		se retirea,	,			Own	Home	
d 2	Hygi Hygi Int.	Be Co	17. Father's Name (First, Middle, Last)	4				T	18. Mothe	r's Name	(First, Middle,	Maiden Su	mame)	
/lan	ould be Mental Parksd c	To B	Yoon Sik Kim						Tae	Choi	L			
Maryland 21215-0036	alth and P		19a. Informant's Name/Relationship (7) Joong Lee (Hush				•				<i>l Route Numbe</i> Cmantowr	. ,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show among in july or other treumatic event, the Madical Examinat must be notified at an once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Place of Dispo cometery, cres rbeck				June 200	9, 06,		tion - City or T	own, State	
Balti	permit. Depertrements any injugance.		21. Signature of Funeral Service Licen	by						/ol Fune or. Gait			1. 20877	
3760,	Physician /Medical Examiner white prival-transit per prival-transit pe	ical Examiner	23a. Part1. Enter the disease, or companies, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a d. Due to (or as a d.	e. Can conseq	uence of):			, com as					Approximate Interval Between Onset and Death
P.O. Box 68	es that the death certificate be executed igned by the ettending physician and be detached for use as the buriat-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3	□Ectopic pi □ Other (sp					230	I. Date of delive Month	very Day Year
ds, P	requires that the een signed by th nould be detache	d by P	Part II. Other significant conditions o	ontributing to death bu	it not res	ulting in the u	nderlying o	ause give	en in Part I.			baccouse es 2		the cause of death?
Records,	> 0 to	omplete									24a. Was a autop: perfor	med?	prior to co death?	opsy findings available ompletion of cause of
ta	en: T tificat tor, pi	25. Was case referred to medical 26. Place of Death (Check only one)									1 Li Yes	2U NO		
Division of Vital	To the Hospitel or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpaties 28a. Date of Injur (Month, Day	28b. Time of Injury		8c. Injury Work	4 🗆 14u	1	me 5 Resid			₩ Hospice	
Division	el or Atten s after deat il Director: id in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined							28f. Location (S City or Tow		lumber or Rui	ral Route Number,	
	ne Hospit n 24 hours ns Funera	Medical C											stated. to the cause(s)	
	Within To the comp	Σ	29b. Signature and title of certifier	^			290		number		2		igned (Month,	
	6		· CX/C	1				D356	35			June	6, 200	06
_	•		30. Name and address of pers an who Dr. Joseph Kapla	n M.D. 600	1 Mu	incaste		.1 Rd	. Roc	kvi1	1e, Md.	2085	55	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 8 200	32. Registra	r's Signa	arure enura	the s							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ırylan		artment o			ental Hy	giene Reg. No.	006	19794
		w	Decedent's Name (First, Middle, Last)						I	2. Date of De	ath		3. Time of Death
	Physic		William	0.	Ly	mch				Month	ne 5	Year 2006	1432 M
	/Medi Examii		4a. Facility Name (If not institution, give s	street and number)			4b. City, Tow	n, or Locatio	n of Death			ounty of Death	1.132
			Peninsula Regiona	i Madical C	pat	er	SALIST	DUMAN			w	icomic	41
	Funeral	7	5. Social Security Number J 6. Sex	3		last birthday)	If Under 1 Ye Months Da	ar If Und	er 24 Hrs.	8. Date of Bir 4/3/19	th Year)	9. Birtho	lace (State or Foreign
	Director		577 – 26–9395	M 2□F	91	Yrs.	WOTHING Da	ys Hours	S IVIII1,	4/3/19	15	Del	aware
_	pu .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						04 1-14 02 11 2
1.	th the Marylan or 28a-f show	7	Maryland Wicomic			Salisbu						1	0d. Inside City Limits 1X□ Yes 2 □ No
5	he M	Director	10e. Street and Number	.0		ATTOOU							
9395		늅	609 Roger Street				10f. Zip Cod	804			_	n of What Cour SA	ntry?
	eath w	Funeral		12. Was Decedent E	ver in II	S 13 1	Was Decedent		Origin? /Sne	ody Vac or No		Race - Americ	an Indian
-26 36	b 2 8	F.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 N			f Yes, specify C	uban, Mexic	an, Puerto I	Rican, etc.)	, 14.	Black, White,	etc.
).).)36	urs aft	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes 2 X I	No Specif	fy:		Sp	pecify: wh	ite
70.0	within 72 hours after ene. then "natural", or ite	Completed	15. Decedent's Educ	cation		16a. Deced	dent's Usual Oc	cupation		-	16b. Kind	of Business/Inc	dustry
5	F - F - 7	ple	(Specify only highest grade	College (1-4or 5-	+)	(Give	kind of work do DO NOT use re	ne during mi tired)	ost of workii	ng			
213	d with the state of the state o	S	3	_	-	Adver	tisemen	t Ins	taller	:	Clea	ar Chan	nel
रे ह	be filed wit ital Hygiens of other the	Be (17. Father's Name (First, Middle, Last)							(First, Middle		тате)	
Lynch 577-3 Marvland 21215-0036	2 should be filed with and Mental Hygiene. Ie marked other the aumatic event, the b	10	George Handy Lyn	ich				S	tella	Mae Go	rdy		
	2 sho and le m		19a. Informant's Name/Relationship (Type				g Address (Stre						Code)
			Margaret H. Lynch	/wife	,		Roger		Salisk	oury, M	D 2180	04	
Lyhn altimore.	es 1 a of Hee of Hee if item or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐R	emoval from State	20b. P	tace of Dispo- emetery, cren	sition (Name of natory or other)	place)		ate	20c. Locat	ion - City or To	wn, State
يّ ك	Pages ment of ent: If it ury or o		4 □ Donation 5 □ Other (Specify)	amorar nom Glato	Pa	CK COMIT CO	Memoria	ат	6/10	/06	Sal	isbury,	MD
Ball	permit. Pages Department of Importent: If I eny Injury or one		21. Signature of Funeral Service Opense	of CFS/	0	11 5	olloway Ol Snow	rfuhe Hill	ral Ho Rd.,	me Pro Salisb	fessicury, N	onal As 4D 2180	sociation 4
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused	the death	n. Do not ente	er the mode of o	tying, such a	as cardiac o	respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ather	och	L'	61.	a scul	6- 0	0			Onset and Death
	/Medical		resulting in death)	Due to (or as a		uence of):	undial	/ascor					2040r
	Examiner		Sequentially list conditions.										
	D ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	uence of):							
	cate be executed only sician and the burial-transit	Cam	that initiated events cresulting in death) Last										
90.	oe ex		and the state of t	Due to (or as a	consequ	uence or):						- 1	
8760.	cate be executed physician and the burial-transit	dical	d	-	_						-	-	
9 ×	eath certific attending p		IF FEMALE:	3c. If yes, outcome o									
Box	aath c atten for us	lan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	□ Fetal	death 3 🗆	Ectopic pregna				23d.	. Date of delive Month	ry Day Year
	he de the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ime or de	am 5⊔	Other (specify)						
0	The law requires that the death certificate hes been signed by the attending to age 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions con	tributing to death but	t not resu	ulting in the un	iderlying cause	given in Pari	t I.	23e, Did to	obacco use	contribute to th	e cause of death?
ds	uires sign	d b	Chronic Oboka	Air Au	Man "	0.00 /	20	•			res 2□N		
jo	w require been signaled to should to	ete		CT10: (10)	gnesti je	47				-			
Ř	ne lav	gE								24a. Was autop	an 2. sy rmed?	4b. Were autop prior to con death?	osy findings available npletion of cause of
<u>a</u>	n: Th ficete r. pa		05.00							1□ Yes	2 X No		2 No
Division of Vital Becords.	Physician: The latter this certificete he ral director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:			\(Othor		(Check only o			
o to	Phys r this ral di	7	27. Manner of Death	1 Inpatien		ER/Outpatient 28b. Time of	2007	*		le 5 ☐ Resid 8d. Describe f		Other (Specify)
o	ding th: Afte	tlor	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	28c. In V	Vork? □Yes 2.□	1		.or injury oc	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
<u></u>	Atter dea octor	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At ho	me, farm, stre				8f. Location (5	Street and N	umber or Rural	Route Number,
á	efte Olive din t	Certification:	4 Homicide	building, etc.	(Specify)				City or Tox	vn, State)		
	spite nours ners / fille	a	29a. Certifier 1X Certifying Phys	ician: To the best of	my know	wledge, death	occurred at the	time, date a	and place, a	nd due to the	cause(s) and	d manner as sta	ated
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examin	er: On the basis of e and manner state	examınat	ion and/or inv	estigation, in m	y opinion, de	ath occurre	d at the time,	date and pla	ce, and due to	the cause(s)
	Vithir To th	ž	29b. Signature and title of certifier				29c. Lice	nse number			29d. Date sig	gned (Month, D	Day, Year)
	2		1///	in			0	249	86		6/0	4/20	04
	(X)		30. Name and address of person who con	mpleted cause of dea	ath (Item	23a) (Type, F	rint)				-/-	1	
	6		Robert S. Reilly	MO 56	01	quers -	6 Da	Biol	Coli	hum	M.J.	2/80	7/
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signat	ure		V.VI	>9115	DUST.	riot.	-100	1
	Registi	rar	JUN 0 8 20	06 1000.		H. A.	made a			-			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Amend #10c & #10e per/fh 06-08-200 Gerificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 615AM **Physician** Linda L. Mullineaux 3 2006 LHE /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springfield Hospital Center Sykesville Carroll 5. Sociel Security Number If Under 24 Hrs. If Under 1 Year Birthplece (State or Foreign Country)
 M 2 6 Sex 7. Age (In yrs. last birthday) Funeral Deys Hours 213-88-3400 1 ☐ M 2 💆 F Yrs. 45 Director Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Columbia r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 7014 gentle Shade Ho ward 1 No 2 No Funeral Director 10e. Street end Number 7014 Gentle Shade 10f. Zip Code 10g. Citizen of What Country? Co (ambia 21045 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 (XIII)No If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) None 12 None Itam 27 is marked other other traumatic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be of Haalth and Mental Lary Jane Mullineaux Robert Lee Mullineaux 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dottle Ruber 7
20a. Method of Disposition - Cousin 3430 Old Hanover Road, Westminster, Maryland 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Methodist Cem. 6/8/06 Damascus, Maryland 22 Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Licenses ot 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Myocordial minutes Examiner by Physician/Medical Examiner Years Coronary Heart Wisease as the bunal-trensit The law requires that the death certificete be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, bronic Obstantive Pulmonary Disease that initiated events resulting in death) Lest Due to (or es a consequence of) ettending p esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2☑ No 3 ☐ Probably 4 ☐ Unknown Dennersive Disonder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 26 INO cartificate 1 Ves 1 ☐ Yes 2 ☐ No or Attanding Physicien: diractor. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury deeth. 1 ☐ Yes 2 No 2 Accident within 24 hours efter deett To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Suha Ozem, Ma D0012480 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 9745 Gingerwood Drive, Edlicott City, MD. 21042

Registrar **DHMH 16 Rev 6/95**

State

Sicha OZGUN.

8 2008

31. Dete filed (Month, Day, Year) JUN 0

distrar's Signature

		ľ	1 - For State Registrar	State of Marylan		artmen rtificat			nd M		giene Reg. No.	2006	19	796
	Physici		1. Decedent's Name (First, Middle, Last, Louise C.	Miller						2. Date of Dea Month June		006 Year	3. Time of 4:55	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		Oxor	n Hi				4c.	County of Death		s
	Funeral Director		5. Social Security Number 239–36–3440 Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birt (Month, Day Jan. 17,	y, Year)	Co	nplace (State of untry) Carolina	11.7
	B Maryland	ctor	10a. State 10b. County Maryland Prince Geo		xon Hil								10d. Inside Cit 1 ☐ Yes	
	th with th	ai Director	10e. Street and Number 1530 Deep Gorge Cour	t		10f. Zip	20745				10g. Citiz	zen of What Co	untry?	
036	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mentel typiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ahow any figury or other traumatic avant. The Medical Examinat must be notified at ance.	by Funerai	11. Marital Status t ☐ Never Married 2 ☐ Married 3 ☐ Widowed ★☆☆vorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2000No If Yes, Give Year or Dates:	1	Was Deced I Yes, spec 1 ☐ Yes	cify Cubar	spanic Origi n, Mexican, Specify:	in? (Spe Puerto P	offy Yes or No- tican, etc.)		14. Race - Amer Black, White Specify: Black	e, etc.	
1215-0	within 72 ho ane. Ihan "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		life. (dent's Usua kind of wo DO NOT us iance	rk done d se retired)	uring most	of workin	g		nd of Business/l		
Maryland 21215-0036	uld be filed v fentel Hygie rkad other tic avant, th	To Be Co	17. Father's Name (First, Middle, Last) Harry Courts		Compr	Tarice	Specia		_	(First, Middle,			vernment	
Mary	th and N		19a. Informant's Name/Relationship (7) Angela Parker / Daugh							Route Numbe		Town, State, Z		
Baltimore,	Peges 1 er nent of Hee ant: If item ary or other		20a. Method of Disposition 1XXXBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. P	lace of Dispo emetery, cren ington I	natory or o	ne of other place)	D	ate	20c. Lo	cation - City or T	Town, State	
Balt	permit. Depertr Importa		21. Signature of Cheral Service Licens	4	Ge 61	Name ar Porge	Address P. Oxon	s of Facility Kala Hil	as E l Ro	unera	l Ho	ome, P	<mark>А</mark> . MD 207	45
2	Physician	è 1	23a. Pan . Exter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line. CARDIAC AR			le of dying	, such as c	ardiac o	respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
	/Medical Examiner	Je.	Sequentially list conditions,	Due to (or as a consequence HYPERTHYRO Due to (or as a consequence	IDISM									
8760,	death certificate be executed a ettending physicien and id for use as the burial-transit	I Examine	Cause (Disease or injury	Due to (or as a consequ										
9	ntificate ng physi s as the b	Medical	IF FEMALE:	d							T			
.O. Box	es thet the death certificing of the detached for use as be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pr Other (sp					2	3d. Date of dela Month	-	ear .
ords, P	The law requires thet the ste has been signed by the page 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the ur	nderlying c	ause grve	n in Part I.	_		bacco us	se contribute to	the cause of de	
Vital Record		Completed									sy med? 2424No	24b. Were aut prior to c death? 1 \(\text{Yes}	topsy findings a completion of ca	vailable use of
fVit	Phyalclan: rthis certific ral director.	To Be	25. Was case referred to medical examiner? 1XXYes 2 No	lospital:	ER/Outpatien	it 3□ DC	Othe	_		Check only one	-	Other (Spec	ntv)	
Division of	To the Hospital or Attending Ph within 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	Certification;	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 Y		2	8d. Describe h			,	
D X	urs efter d urs efter d iral Direct		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify						City or Tow	n, State)	Number or Rui		90 <i>r</i> ,
	To the Hospital within 24 hours e To the Funeral I completely filled	Medicai	29a. Certifier (Check only one) 1XXCertifying Phy 2 ☐ Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred vestigation	at the time, in my op	e, date and inion, death	place, a	nd due to the o d at the time, o	ause(s) a date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the compl	W	29b. Signature and title of certifier			290	: License 12300	number		à		signed (Month) June 6, 20		
R	(6)		30. Name and address of person who co			,	101 1			DC.				
	Sta Registr		Alfred Burris MD 31. Date filed (Month, Day, Year) JUN 0 7 2006	1328 Southern A 32. Registrar's Signal	venue S	E. #	214	Washing	gton•	DC 200)32			

State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 2006 June 7:45 7, Dina Mutterperl Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □XF Yrs Director 098-24-9188 99 Poland Poland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mentel Hygiene ordent: if Itam 27 is marked other than "natural", or Itama 23a or 28a-1 show injudy or other traumatic event, the Medical Examinat must be notified at injudy at the model. 1 ☐ Yes 2/☐ No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 Completed by Funeral 14508 Homecrest Rd USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify 3 → Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ Aaron Mindel Hindabella Friedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11201 Rose Ln, Silver Spring, MD 20902 Rachel Goldfarb/Daughter Importent: If Item any injury 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery Jun 8, 2006 Adelphi, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition **Physician** Acute Cerebrovascular Accident /Medical resulting in death) Due to (or as a consequence of) Examiner Large Massive Infract on Brain Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit Attending Physician: The law requires that the death certificate be executed Altered Mental Status that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the e d be detached f 1 ☐ Yes 2 ☐ No Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 ☐ Yes 2 ☐ No 2₩ No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ne husprise.
In 24 hours after death.
the Funeral Director: After this of ٩ 1 ☐ Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai completely the within 7 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) of certifier DR63579 June 7, 2006 of death (Item 23a) (Type, Print) 1500 Forest Glen Rd, Silver Spring, MD 20910 Maria Tayag, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene) For State Registrat Certificate of Death Reg No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month Day Year **Physician** 2006 3:22 6 Mauro Francisco Montesino June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Montgomery Holy Cross Hospital Spring If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1₩ 2□F Months Hours Director Jan. 29, 1943 578-72-7463 El Salvador Usual Residence of Decedent 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 17 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinatinatics could be 1 Yes 2 No Directo Maryland Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 USA 55 Orchard Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify. Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced El Salvador White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within in nent of Heelth and Mental Hygiene. Int: if item 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) 12 Capital Hilton Banquet Attendent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Unknown Montesino Leonor Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Orchard Drive Gaithersburg, Maryland 20878 Azucena Montesino Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: if it any injury or o 1 ☐ Burial 2 ICC Cremation 3 ☐ Removal from State Metropolitan 4 ☐ Donation 5 ☐ Other (Specify) June 7,2006 Alexandria, Virginia Crematory June 7,2006 Alexandria, 22 Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee Kichard I Gales 1500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) a Metastatic Hepatocellular Carcinoma 6 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Physician/Medical d IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e P.O. The law requires that the 9 Unknown s been signed t should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan page 2 s 1 ☐ Yes certificete 1 Yes 2√2 No 2∏ No of Vital Physicien: After this certific funeral director. 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 X Natural 5 Pending death. 1 TYes 2 TNo investigation 2 ☐ Accident hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 To the ... within 24 hours. To the Funeral D' 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 52503 June 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shailesh Sheth, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature 8 2006 Registrar

		-	For Stata Ragistrar	State of I	Marylan	•	artmen <i>tificate</i>			and M	lental Hyg	iene g. No.	06	19799
	Physicia	an	1. Decedent's Name/(First, Middle	M/lest			71.2				2. Date of Deat Month	h Day	Year 7)6	3. Time of Death
	/Medic Examin		4a/ Facility Name (If not institution	n, give street and numb	er)		4b. City,	Town, or	Location of	of Death		4c. Cour	ity of Death	
	Examin	Č.	RENAISSANCE GARDE			HOME	SILVE	R SPR	ING			MONTG	OMERY	
	Funeral		5. Social Security Number	6. Sex 7. 1 M 2 AF	Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthi	place (State or Foreign ntry)
	Director		296-05-5086	10 M 20FF	87	Yrs.					JUNE 1, 1	.919		OHIO
	and	1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	f sho	ō	MARYLAND MONTGO	MFRV	STIV	ER SPRI	NC							1 ☐ Yes 2 🖾 No
	the 28a	Director	10e. Street and Number	PERT	3111	EK SIKI	10f. Zip	Code			1	0g. Citizen o	of What Cou	ntry?
	3a or		3160 GRACEFIELD R	OAD, APT. 1417	7		2	0904				U.S.A		
	deat	Funerai	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13. V	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White,	
9	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Medical Exactinat mant te notilised at	Fu	1 Never Married 2 Mar	ried 1 ☐ Yes 2			1 ☐ Yes		Specify:	,	,	Spec		
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Date	s:	16a D	danda Harra	1.0	tion.				AAIIT	
7	n 72 l	Completed	(Specify only highe	nt's Education st grade completed)		16a. Deced (Give life. L	ients Usua kind of woi DO NOT us	k done a	<i>luring</i> mos	t of work	ing	16b. Kind of	Business/in	idustry
12	withi iene. than	dwo	Elementary/Secondary (0-12)	College (1-4	or 5+)	HOMEMAI		,				OWN HOM	Ε	
	i filed I Hyg other	BeC	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	e (First, Middle, I	Maiden Sum	ame)	
lar	uld bg Aenta rked tic av	To B	ALVIN	LIND					ROBER	TA		MIL	LHOM	
Maryland	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or Itams 23a or 28a-f show appring to other traumatic avent, the Maried Examinet must be notified at once.		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	ng Address	(Street a	and Numbe	er or Rur	al Route Number	City or Tow	m, State, Zip	o Code)
	and in 27		JACK MILLER/SON		201 5				, HIGH		MARYLAND			
ore	Fite P		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from Sta	1 0	lace of Dispo emetery, cren	natory or o	ne or ther place	9)		Date	20c. Location	n - City or I	own, State
Ē	tmen tent: tent:		`4 □Donation 5 □Other (S		PAI	RKLAWN M				06/09	/2006 R	OCKVILL	E, MARY	/LAND
Baltimore,	Deparmine Department Important in Sunce.		21. Signature of Funeral Service	Du dour	,		Name an			-	OME, INC.			YLAND 20904
			23a, Part 1. Enter the disease, of	r complications that cou	sed the death								NG, MAR	Approximate
	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cau	nscleu	oper	lear	+)	SCA	SC				Onset and Death
E	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):			1					
		io i	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	uence of):							-	
	utad J ansit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events	S c.										
oʻ	te be executad ysician and ie burial-transit	Exa	resulting in death) Last		as a consequ	uence of):								
8760,		ical		d										
9	death certifics e attending ph od for use as tl	Physician/Med	IF FEMALE:	200 16 100 01100				-				1		
Box	leath certific attending p I for use as f	lan/	23b. Was decedent pregnant in the past 12 months?		me of pregna n 2 ∐ Fetal it at time of di	death 3	Ectopic pr						Date of deliv Month	ery Day Year
o <u>i</u>		yslc	1 □ Yes 2 □ N o 9 □ Unknown	9 Unknow		batti 5_	10mer (3p	6011y)						
a	that the	by Ph	Part II. Other significant condit	ions contributing to deal	th but not resi	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to	oacco use co	ontribute to t	he cause of death?
rds	quires on sign										1 □ Ye	s 2 2 No	3 🗌 Prol	bably 4 □Unknown
ecords,	law requires as baen sign 2 should be	Completed									24a. Was a		. Were auto	opsy findings available ompletion of cause of
$\boldsymbol{\Xi}$	The te his	E									perfor		death?	2 No
Vital	sicien: 7 certifica rector, p	Bec	25. Was case referred to medical examiner?	ai					26. Place	of Deat	h (Check only on			
of V	Physicien: r this certific ral director,	안	1 ☐ Yes 2 No	Hospital: 1 Inc		ER/Outpatier			4 KATAR	arsing Ho	me 5 Reside			fy)
n c	ding P h. After t funera	ion:	27. Manner of Death 1 Natural 5 Pend	rig .	Injury Day Year)	28b. Time of Injury		8c. Injury Work		Na	28d. Describe ho	w injury occ	urred	
Sio	Attending r death. actor: After by the fune	icati	3 ☐ Suicide 6 ☐ Could		Injuny . At he	ome farm etr	M root factor		Yes 2□	NO	28f Location (Si	reet and Nur	mber or Rur	al Route Number,
Division	l or At after o Dirac I in by	ertification;	4 Homicide deten	mined 200. Flace of building	, etc. (Specif	y)	cot, ractory	, omce			City or Town			
	To the Hospital or Attent within 24 hours after deatl To the Funeral Diractor: completely filled in by the	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Dayle signed (Month, Day, Year)												
	To th withir To th comp	Me	29b. Signature and title of cartifi	er ///					number		2	9d. Dayle sign	ned (Month,	Day, Year)
	1		* Kleh	Messel 11	0		1	10043	375			6/6/	06	
	/		30. Name and address of person											
			KAREN MERRITT, 31. Date filed (Month, Day, Year		GRACI	-	ROAD	, SI	LVER	SPRI	NG, MAR	YLAND	20904	
	Sta Registi		JUN 8	2006	MAJ A	y. A	all?							

			For State Registrar	State of Ma		artment of Hea rtificate of De		ntal Hygien	6000	19800
	Physici /Medic		Decedent's Name (First, Middle, La	Jack H.	Morton		2	Date of Death Month	S 2004	1.2
	Examin		4a. Facility Name (If not institution, given Washington Cour	nty Hospita			stown, M	O . K	c. County of Death ashingtor	n .
	Funeral Director			Sex 7. Age 1 2 M 2 □ F	77 Yrs.		Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea 6-29-28	9. Bitth	place (State or Foreign) ntx) Cove Tannei
	e Maryland e-f ehow	Director	10a. State 10b. County PA Fulton		10c. City, Town or L McConne					10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	ath with th	rai Dire	10e. Street and Number 311 Thorton I	rive		10f. Zip Code 17233		10g. C	USA	
980	be filed within 72 hours after death with the Maryland tal Hygiene. In other then "natural", or Iteme 23e or 28e-f ehow event, the Medical Examinar must be motified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Be Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2 ☑ No S	anic Origin? (Specif Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: W	
Maryland 21215-0036	e filed within 72 ho al Hygiene. other then "natur vent, the Medical	Completed	15, Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	dent's Usual Occupation of kind of work done during DO NOT use retired) Farmer	n ng most of working		Kind of Business/In	
/land	should be filed ind Mental Hygi i marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last D. Kenneth Mo				. Mother's Name (F	First, Middle, Maide ace Henry	,	
	s 1 and 2 should f Health and Mer Item 27 is marke other treumatic		19a. Informant's Name/Relationship Mary Jane Mot	•	311	ng Address (Street and Thorton Dr		ellsburg,		3
Baltimore,	Pages nent o ant: If ury or	100000	20a. Method of Disposition 1	fy)	Union	matory or other place) Cemetery	6-2-(06 Mc	:Connells	ourg, PA
Ba	permit. Departi	1 (2	23a. Part1. Enter the disease, or con	aller to. #		2. Name and Address o			bung IPA.	17233 Approximate
	Physician /Medical Examiner	iner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as	a consequence of):		Peilure pulm		Jidoos.	Interval Between Onset and Death
,820,	cate be executed physicien and the burial-transit	dical Examin	that initiated events resulting in death) Last	c	a consequence ol):					
.O. Box 6	The law requires that the death certificate has been signed by the attending transge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 [□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
<u>α</u>	w requires that been signed b should be deta	ě	Part II. Other significant conditions	contributing to death be	ut not resulting in the u	ındəriying causə givən ir	n Part I.	23e. Did tobacco	ouse contribute to t	he cause of death? bably 4 □Unknown
Vital Records,		Completed						24a. Was an autopsy performed?	prior to co	opsy findings available empletion of cause of
Vita	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 ☐ ER/Outpatie	Other	S. Place of Death (0 Flotter (0	La .
ion of	dlng P. After fune	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Da)		of 28c. Injury at Work?		d. Describe how in	6 ☐Other (Special of the following occurred)	(y)
Division	ે ફ્રેફ્રેંડ	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At home, larm, st c. (Specify)	reet, factory, office	281	f. Location (Street and City or Town, Sta	and Number or Run ite)	al Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or in	th occurred at the time, onvestigation, in my opinion	on, death occurred	at the time, date a	nd place, and due t	o the cause(s)
	with To	×	29b. Signature and title of certifier	,		29c. License nu	157	5-	Oate signed (Month, -31 -2006	
Ö	H-6		ABOUL WAH	completed cause of d	eath (Item 23a) (Type _ (2-824 _ 0)	+KHI(AVE	HAGER	STORNY.	MD 21	742
J.S	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 9 20		ar's Signature	whi				

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 2006 11:32A M June Frances Louise Flora Moyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 11 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🕱 F 79 Yrs. 1927 Frederick, MD 220-26-0205 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ns 23s or 28a-f shormust be notified at 1 Yes 2 □ No MD Frederick Brunswick Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21716 26 N. Virginia Avenue IISA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. the Medical Examiner 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 □ Divorced natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic avant, Int. M. Elementary/Secondary (0-12) College (1-4or 5+) Cashier YMCA, Brunswick, MD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Franklin Anders Lucille Annie Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10130 Boston Street, Frostburg, MD Carol Ann Sivic 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If its any injury or of ance. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mark's Cemetery 6/8/06 ` 4 Donation / 5 □ Other (Specify) Petersville, MD etricite Lichae William 22. Name and Address of Facility John T. Williams Funeral Home Williams, Owner Barbara A. 21716 100 Petersville Road, Brunswick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each inc. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) meun Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissase or irrjury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No. 24a. Was an autopsy sectersier 1 Yes 2 No Be eferred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₽ No Certification: To his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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JUN 0 8 2006 State Registrar

			a FOI	epartment of Health and M Certificate of Death		iene [] { _{eg. No.}	06 19802
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Goldrick Magee		2. Date of Death Month Qune	Day	Year 2300 M
	Examir		4a. Facility Name (If not institution, give street and number) Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	4b. City, Town, or Location of Death (AS + Orange of State of Sta	8. Date of Birth		of Death A but 9. Birthplace (State or Foreign
B	Funeral Director		457 11 20 5	rs. Months Days Hours Min.	8. Date of Birth (Month, Day, Apr. 8,	1927	Maryland
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town	orLocation Federalsburg			10d. Inside City Limits 1 🙀 Yes 2 🗆 No
	with the a or 28s	Direc	10e. Street and Number 604 Fair Haven Apartments	10f. Zip Code 21632		Og. Citizen of W	
980	hours after death with the Maryland tural, or items 23a or 28a-f show al Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 1 □ Never Married 2 ☑ Narried 3 □ Widowed 4 □ Divorced 1 □ Never Married 2 ☑ No If Yes, Give 1 □ SYes 2 □ No If Yes, Give 1 □ SYes 2 □ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race	States - American Indian, k, White, etc. Black
21215-0036	in 72	Completed	(Specify only highest grade completed) Flementary/Secondary (0.12) College (1.4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Cuck Driver	ing	16b. Kind of Bu	,
Maryland 2	be filed ntal Hyg ed other event,	To Be Co	17. Father's Name (First, Middle, Last) Robert Leonard Magee		Mae Tur	ner	
	s 1 end 2 should if Health and Mer item 27 is marks other traumatic		Constance J.M. Hawkins/ 56	Mailing Address (Street and Number or Auro 44 Whitby Ave.,	Philade	lphia,	PA 19143
Baltimore,	Pages I nent of h ant: If ite ury or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lastern	v, crematory or other place) Sh. Vet. Cem. 06/16	0/06 H	Hurlocl	City or Town, State
Bal	Deportr Imports any inju		21. Signature of Fineral Service Licensee	22. Name and Address of Facility Fra 216 N. Main St., Fe	ederalsb	urg, MD	21632
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	las Flutter	or respiratory arre	est,	Approximate Interval Between Onset and Death
58760,	Examined executed the burial-transit the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	Artery D	iseer	e	204020
.O. Box (death certifi e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date Mon	e of delivery hth Day Year
ords, P	The law requires that the site has been signed by the bage 2 should be detache	þ	Part II. Other significant co diti, s contributing to de th but not resulting in	the underlying cause given in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
Vital Record		Be Completed	Cardiac A-V block Bio 25. Was case referred to medical	ng- old dy Cardia 26. Place of Deat	24a. Was ar autopsy perform 1 Yes 2	y p ned? d No 1	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
of	d 5 7	ို	27. Manner of Death 28a. Date of Injury 28b. T		me 5 Reside	nce 6 Othe	
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	Certification:	1 Natural 5 Pending (Month, Day Year) In 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Str City or Town		er or Rural Route Number,
נ	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Madical Examinar: On the basis of examination and and manner stated.	, death occurred at the time, date and place, Vor investigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and mar ate and place, a	nner as stated. and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier, MCJRyalingh MD, FA			6/13	(Month, Day, Year)
-			30. Name and address of person who complete cause of death (Item 23a) (M. Christaduss Rajusingh mb 5	Type, Print) 22 Idlewild Aus	Zastn	n MD	2160/
	Sta Regist		31. Date filed (Month, Day, Year) 32 Registrar's Signature	Some of a			

Decaded to Name (First, Medica). Last) John Robert McNeal, Sr. 2 Date of Death Month John Robert McNeal, Sr. 2 Date of Death Month John Robert McNeal, Sr. 2 Date of Death Month John Robert McNeal, Sr. 4 Seculty Name (First Institution, give street and number) Harford Memorial Hospital Harford Memorial Hospital Briefeld Fourcal Director Function				For State of Maryla 1 - State Registrer	nd / Department of Health Certificate of Deat	4	glene 2006	980
## AFFORD WARRY PLANS TO COMPANY AND THE PROPERTY OF THE PROPE		Physicia	an	1. Decedent's Name (First, Middle, Last)	Sr	Month	Day Year	
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Second Security Number Second Security Number Security Secur		Examin	er		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Harford	
DOUGH TO THE PROPERTY OF THE ACCOUNT OF THE COURT OF THE				5. Social Security Number 6. Sex 7. Age (In yrs 222-30-0542 59	s. last birthday) If Under 1 Year If Und	er 24 Hrs. 8. Date of Bir s Min. (Month, Da	th ky, Year) 9. Birthplace (Country) 9.46 Delawa	State or Foreign
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			_ Stete	State of Maryland /		tment of He		Mental Hy	ygiene Reg. No.		6 19	804
			Registrer 1. Decedent's Name (First, Middle, Last)		00/1/	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of D			3. Time o	f Death
	Physicia	ın	Mary Elizabeth Newk	d wle				June 7	200		12:34	A ^M
	/Medic	ai	4a. Facility Name (If not institution, give s		4	b. City, Town, or	Location of Death			County of De		- А
	Examin		Kline Hospice House	·	М	t. Airv			F	rederio	- lr	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth	9. E	Birthplace (State	or Foreign
	Director		578-05-4100	M 2X F 88	Yrs.	Months Days	Hours Min.	July 1			Country) shingtor	, DC
	g		Usual Residence of Decedent									
	how	_	10a. State 10b. County	10c. City, Tov	vn or Locat	tion					10d. Inside C	2 X No
	Ba-f-	cto	Maryland Frederick	Freder					1			
	iih th	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What	Country?	
	ath w		7045 Basswood Road			21703			USA	11.5		
	er de	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. Wa	is Decedent of His es, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	o Rican, etc.)	10-	Black, W	merican Indian, hite, etc.	
36	hours after death with the Maryland tural: or Items 23a or 28a-f ehow al Examinan must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1	1 🗆]Yes 2⊠No	Specify:			Specify:	White	
9	hour tural		15. Decedent's Educ		. Deceden	nt's Usuat Occupa	ition		16b. K	ind of Busine		
5	filed within 72 Hygiene. Ither then "nate ont, the Medical	Completed	(Specify only highest grade	completed)_	(Give kin	nd of work done d NOT use retired)	uring most of wor	king			Institut	P
7	with iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	ntrac	t Admini	istrator			lealth		
0	Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middl				
<u>la</u> u	Henta Ked Ked	To B	William Raymond Fit	zgerald		A	Annie El:	izabeth	Huto	chins		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Meantal Hygiene. Is marked other then "natural", or items 23a or 28a-f show aumatic event, the Marical Examinar mast be notified at		19a. Informant's Name/Relationship (Typ		b. Mailing	Address (Street a	<i>nd Number</i> o <i>r R</i> u	rai Route Num	ber, City o	r Town, State	e, Zip Code)	
Ž	aith a		Geraldine E. Jansen	, daughter 36	787 в	reakwate	er Run, S	Selbyvi	11e,	Delawa	are 199	75
altimore,	permit. Pages 1 and 2 should be Department of Heatils and Menta Importent: If Item 27 is marked any Injury or other traumatic ev once.		20a. Method of Disposition	20b. Place o	of Dispositi	ion (Name of tory or other place		Date			or Town, State	
Ë	Page nent c nt: # iry or		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Denation 5 ☐ Other (Specify)		gton	Nationa]	L Cem 7/6	5/2006	Ft.	Mver.	Vircini	a
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m	F OF F		- Lyandur	Seiser MO099	9 106	East Ch	nurch St	reet, F	reder	cick, N	MD 2170	1
			23a. Part1. Enter the disease, or complice shock, or heart alture. List only on	cations that caused the death. Do	not enter t	the mode of dying	, such as cardiac	or respiratory	arrest,		Approxima Interval Be	te tween
	Physician		Immediate Cause (Finat disease or condition								Onset and	Death
*	/Medical		resulting in death)	Liver Cancer Due to (or as a consequence	of):						Months	
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oʻ	e exe ien au urial-t		resulting in death) Last	Due to (or as a consequence	of):							
8760,	cate be executed bhysicien and the burial-transit	dlcal										
မှ	The law requires that the death certificate be executed ete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	0	IF FEMALE:									
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat		ctopic pregnancy				23d. Date of Month		Year
<u>.</u>	the a	SIC	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 □ 0	Other (specify)					,	
<u>~</u>	that the de led by the a detached	Phy	Part If. Other significant conditions con	tributing to death but not regulting	in the unde	arkina causa awa	on in Part I	23e Did	tobacco i	ise contribute	to the cause of	death?
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<u>=</u>	The cete!	ပို						1 ☐ Yes		death 1 🗆 Y	es 2□ No	
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_	Attending Physicien: r death. ector: After this certificaby the funeral director,	2	1 ☐ 105 2 <u>X</u> 110	1 Inpatient 2 ENC		3□ DOA Othe	4 Nursing n	ome 5 ☐ Re			pecify) Hosp	ice
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Division of Vital Records, P.O.	or A after Direction by	art	4 Homicide determined	building, etc. (Specify)	am, sitee	t, factory, office			own, State		TIGITAL PIODIO (VDI)	iber,
_	pitel ours erei filled		29a. Certifier 1 X Certifying Phys	ician: To the best of my knowledg	ne death o	occurred at the tim	e date and place	and due to th	e cause(s)	and manner	as stated	
	Hos 24 ho Fun stely	Medical	(Check only 2 Medical Examir	ier: On the basis of examination a and manner stated.	nd/or inves	stigation, in my op	pinion, death occu	rred at the time	e, date and	d place, and c	due to the cause(s)
	To the Hospitel or Attending Physicien: The I within 24 hours effer death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier			29c. License	number		29d. Da	te signed (Mo	onth, Day, Year)	
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7			30. Name and address of person who co	moleted cause of death (Item 23a	(Type Pri		<u> </u>		o and	17, 21	000	-
	10		Michael A. Tolino,			•	erick. MI	2170	2			
	Sta	te	31 Date filed (Month Day Year)	32 Registrar's Signature		(Marie						
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Decedent's Name (Frist, Middle, Last) Carpenter		1 - For State Registrar	Glale (or marylan	Cer	rtment of H	Death		Reg. No.	UUb	וטטנו
Randolph D. Niles 14. Serve was first estandary as treat and number? 15. School South, Nambur 16. Serve 17			le, Last)						Day	Year	3. Time of Dea
## Sealty Name of the distribution your stream of numbers 40. CMp. Town or Location of Data h 10. Control of Data h 10. CMp. Town or Location of Data h 10. CMp. Town or Location of Data h 10. CMp. Town or Location 10. Location		Randolph D. N	iles							2006	4:17 A
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ACO_98_4455 AT Yes Months Days Hours Min Peb. 28 1959 Country											
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Secondary Consider Seconda	to	Maryland Fred	erick		Kno	xville					1X∏Yes 2□
Samuel Niles Same and Same	irec	10e. Street and Number				10f. Zip Code		-	10g. Citizer	of What Co	untry?
Samuel Niles Security Secu	a D	2713 Wolfe Dri	ve			2175	58		Unit	ted St	ates
Secondary Communication Secondary Commun	ner	11. Marital Status	12. Was De Armed F	cedent Ever in U Forces?	.S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or N to Rican, etc.)	0- 14.		
16a. Decelority in June 16a. Decelority in June			If Yes G	ive evi	1	☐ Yes 2√ No	Specify:		Sp	ecity: W	hite
Samuel Niles Samuel Niles Patricia Lasher				Dates:	16a Decer	lant's I leual Occum	ation		16h Kind	of Rusiness/	Industry
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Samuel Niles Samuel Niles Patricia Lasher	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	_				Cons	struct	ion
Samuel Niles Samuel Niles Wife 19b Mailing Address (Street and Number of Plant Routine City or Town, State, Zip Code)			, Last)				18. Mother's Nar	ne (First, Middle	e, Maiden Su	mame)	
Sus an Niles / Wife 21.13 Wolfe Drive, Knoxville, MD 21758 22b. Marbod of Disposition 1. Detrial 22f. Commains 3 Removal from State 21. Signaprifit Fundation 3 Removal from State 22. Signaprifit Fundation 3 Removal from State 22. Signaprifit Fundation 3 Removal from State 22. Signaprifit Fundation 3 Removal from State 22. Signaprifit Fundation 3 Removal from State 23. Signaprifit Fundation 3 Removal from State 24. Deposition 5 State Frederick, Maryland 25. Signaprifit Fundation 5 State Frederick, Maryland 26. Signaprifit Fundation 5 State Frederick, Maryland 27. State and Address of Facility State free Fundation, Maryland 28. Name and Address of Facility State free Fundation, Maryland 29. Name and Address of Facility State free Fundation, Maryland 20. State Frederick, Maryland 20. State Frederick, Maryland 21. Signaprifit Fundation 5 State Frederick, Maryland 21. Signaprifit Fundation 5 State Frederick, Maryland 29. State Frederick Crematory State Frederick, Maryland 20. State Frederick Crematory State Frederick, Maryland 20. State Frederick Crematory State Frederick, Maryland 21. Signaprifit Fundation 5 State Frederick, Maryland 21. Signaprifit Fundation 5 State Frederick Maryland 21. State Frederick Maryland 22. State Frederick Maryland 23. Does to (or as a consequence of): 25. Was decoded priegrand 25. Was decoded priegrand 26. State Frederick Maryland 27. State Frederick Maryland 28. Due to (or as a consequence of): 28. Was case referred to medical 29. Was case referred to medical 29. Was case referred to medical 29. Was case referred to medical 29. Was case referred to medical 29. Was case referred to medical 29. Was case referred to medical 29. Was case referred to medical 29. Was case referred to medical 29. Signature and Mumbar or Fund House Numb 20. State Free Companion 20. State Free Companion 20. State Free Companion 20. State Free Companion 20. State Free Companion 20. State Free Companion 20. State Free Companion 20. State Free Companion 20. State Free							Patrio	cia Lash	ner		
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23d Part Enter mediate and or complications has visuated the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate		Susan Niles /	Wife		2713	Wolfe D	rive, Kno	oxville	MD 21	1758	
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23d Part Enter heddsaad for complications that shaded the 'easth. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death)	- 1-3	1 □ Burial 2-5 Cremation 1 □ Donation 5 □ Other (Specify)	Fr	ederic	k Cremato	ory 6/8/	/2006	Frede	rick,	Maryland
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Immediate Cause (Final dease or condition resulting in death) a Metastatic Renal Cell Cancer Years	3	1 oumen) Jai	ulper						rick,	MD 21702
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 no 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day You 1 North North Day You 1 North North Day You 1 North North Day You 1 North North Day You 1 North North Day You 1 North North Day You 1 North North Day You 1 North North Day You 1 North North Day You 1 North North Day You 1 North North Day You 1 North Day You 1 North Day North Day You	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b	o (or as a consec	quence of):	nai Celi	Cancer				iears
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25. Was case referred to medical examiner? 1 Yes 2 No	b	Part II. Other signmount contain	tions contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.				
25. Was case referred to medical examiner? 1								aut per 1 🗌 Yes	opsy formed? 2 No	prior to death?	completion of caus
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital: 1 [28a. Dat (Mo	te of Injury onth, Day Year)	28b. Time of Injury	M 1	er: 4 ☐ Nursing H y at k?	Home 5 Res	sidence A	occurred	
(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)			mined 209. Fla bui	the best of my kn	owledge, deat	h occurred at the til	me, date and place	City or To	own, State) e cause(s) an	nd manner as	stated.
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 4 2 4 5 2	edica	(Check only 2 Medica one)	al Examiner: On the and ma	basis of examina	ation and/or in	vestigation, in my o	pinion, death occ	urred at the time	e, date and pl	ace, and due	to the cause(s)
		29b. Signature and title of certif	ier			29c. Licens	e number				h, Day, Year)
	Σ	\ /// h.				1 1	0.1/	~	1.	X	and.
Chitra Rajagopal, M.D. 9715 Medical Center Dr., Suite 221, Rockville, MD 2085	M	I Chihe l	yegene			1)7	245	メ	Jun	u 8	2000

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 31, Day **Physician** Year 9:35A M 2006 George Melvin Newell, Sr. May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Hospice House Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □XM 2 □ F 82 Yrs. Director 180-16-5826 Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itame 23e or 28e-f ehow the Medical Examiner must be notified at MD 1√ Yes 2 No Talbot Director Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 640 Mechlenburg Avenue Apt. 118 21601 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Food Processing/ and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Mechanic Poultry or other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Peges 1 and 2 should be fill iment of Health and Mental H tant: If item 27 is marked ot Martha Ann Collins George Arthur Newell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 640 Mechlenburg Ave., Apt. 118, Easton, MD 19a. Informant's Name/Relationship (Type, Print) Doris W. Newell/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department o Importent: If any injury or once. Hill Crest Cem. 06/07/06 | Federalsburg, MD 22. Name and Address of Facility $Framptom\ Funeral\ Home,\ P.A$ 21. Signature of Funeral Service Licensee. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rostate /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, backing to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 X No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospic 1 ☐ Yes 2 📈 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c, Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending efter death. 1 TYes 2 TNo 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours e To the Funarel C completely filled i 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deshields 509 ave. Easton, Md. 21601

State

Registrar

31. Date filed (Month, Day, Year)

6 2006

32 Registrar's Signature

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			State of Maryla				•	iona (1)	10 A 15 TO 10 B
			1- State Registrar		attiticate of				1 1 5 0 0 7
	5 · "公务"	E.	Decedent's Name (First, Middle, Last)		rincate or	Death	2. Date of Deat	eg. No . h	3. Time of Death
	Physici		Frances F. Otts				Month	Day Yea	ır M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. Cily, Town, o	r Location of Dea	June	7 2006 4c. County of De	2:30 A
		G.,	111 Lexington Drive		Silver			Montgor	mery
i i	Funeral		150 10 7044 1 M 20XF	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)
A.	Director		Usual Residence of Decedent	0 115.			Dec.22,	1915 Te	xas
	yland how		10a. State 10b. County 10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
	an-1 s	Director	Maryland Montgomery	Silver :	Spring				1 ☐ Yes 2 ⊋ No
	vith th	Dire	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What	Country?
	eath v	erai	111 Lexington Drive 11. Marital Status 12. Was Decedent Ever in	11.6		0901	24 M	USA	
	r Item	Funerai	1 Never Married 2 Married 1 Yes 2 No	0.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, W	nerican Indian, nite, etc.
9	ral', o	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify:	Vhite
21215-0036	within 72 hours after death with the Maryland ene. Then "natural" or fleme 23s or 28s-f show he Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of wo	nrkina	16b. Kind of Busines	
121	within ane. then	mp	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done DO NOT use retired	1)		0 11	
0	Hygi ther int,	ပိ	17. Father's Name (First, Middle, Last)	ношег	naker	18. Mother's Na	me (First, Middle, N	Own Home	3
<u>a</u>	should be ind Mental marked o umatic eve	To Be	Frank M. Fly			Stella		,	
Maryland	should Name	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			City or Town, State	, Zip Code)
Σ,	and 2 Balth n 27 I		Altah Glasgow Daughter		Lexington	Drive	Silver Sp	ring,Mary	land 20901
ore	F Ite			Place of Dispo cemetery, crer etropol:	nsition (Name of matory or other place	ce)	Date 2	20c. Location - City	or Town, State
Baltimore,	rimen rimen		4 Donation 5 Other (Specify)		Crematory	Jun.	7,2006 A	lexandria	.Virginia
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	F	rancis J.	Collins	Funeral	Home, Inc	· .
			23a. Part Enter the disease, or complications that glused the de shock, or heart failure. List only one cause on each line.	ath. Do not ent	OU Univer er the mode of dyin	sity Blv g, such as cardia	d.,W.,Sil	<u>ver Sprir</u> st.	ng, MD 20901
	Physician		Immediate Cause (Final						Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Cerebral Va		Accident				2 weeks
	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse						
*	nsit	nine	if any, leading to immediate Due to (or as a conse cause. Enter Underlying Cause (Disease or injury	equence of):					
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/60,	ate be executed hysician and ihe burial-transit	cai	C _d						
_	rtificat ng phy as th								
ŏ	death certifica e attending ph id for use as ti	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Live birth 2□Fe		Ectopic pregnancy			23d. Date of d	
5	the at	Physician/Med	1 Yes 2 No 4 Pregnant at time of 9 Unknown		Other (specify)			Month	Day Year
J.	w requires that the death certifica been signed by the attending ph should be detached for use as th		Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause give	an in Part I	23e Did tob	acco use contribute	to the cause of death?
ds,	uires of be	d by	COPD		y ng cadao give	or			Probably 4 TUnknown
Hecord	s beer	ompieted					24a. Was an	24h Were	autonsy findings available
Ë	sicion: The law certificate has b irector, page 2 si	E O					autopsy perform	ed? prior to	autopsy findings available completion of cause of
		Be C	25. Was case referred to medical examiner?			26. Place of Dea	1 Yes 2		s 2 No
<u> </u>	> 0 T	2	1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatien	t 3 DOA Othe	er: 4 Nursing H	lome 5🛣 Resider	ice 6 □Other (Sp	ecify)
ב	ding Phy th. After thi funeral o	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe how	v injury occurred	
DIVISION	death death ctor: y the	ertificatio	2 Accident investigation 3 Suicide 6 Could not be determined determined	home farm etr		Yes 2 No	28f Location (Str	not and Number of	Rural Route Number,
2	affor affor	erti	4 Homicide determined building, etc. (Spec	eity)	eot, lactory, office		City or Town,	State)	nurai Houte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Saic	29a. Certifier 1 (X Certifying Physician: To the best of my kr	lowledge, death	occurred at the tim	ne, date and place	, and due to the car	use(s) and manner a	is stated.
	the Hin 24 the Fu	edicai	one) Medical Examiner: On the basis of examin	nation and/or inv	estigation, in my op	pinion, death occu	irred at the time, dat	te and place, and du	e to the cause(s)
	To the within To the compl	Σ	29b. Signature and title of certifier	4 0	29c. License	number	29	d. Date signed (Mor	ith, Day, Year)
	10			m.1)		317	J	une 7, 20	06
	-		30. Name and address of person who completed ause of death (Ite Robert Byrne, M.D. 2323 Sou			Ar1i-~	ton Virei	nio 2220	.2
1	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Sign	nature		ALLING	con, virgi	nia 2220	
	Registr		JUN 8 2006 2000	H. Anna	all!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] [For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death June 14, 2006 1447p Lillian E. Phelps 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 415 Cakington Road Havre de Grace 8. Date of Birth (Month, Day, Year) Tanuary 7,1963 If Under 1 Year | II Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number Hours Months Days 1 □ M 2 1 F 43 212-82-9842 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2€ No Oeci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 959 Irishtown Rd. 21901 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes. Give 1 □ Never Married 2 □ Married 1 Tyes 2 X No White Specify: Specify: 3 ☐ Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Beauty Cosmetologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jadwiga Kolodynski Robert Abramowicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jadwiga K. Abramowicz/Mother 959 Irishtown Rd., North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State our Lady of Shrine 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State June 23, Doylestown, PA 4 Donation 5 Other (Specify) 3006 Czestochowa Cemetery 21. Signature Leuneral Service Licensee Name and As ress of Facility Andrew G. Gee Funeral Home 259 E. Main St., Elkton, MD 23a. Part1. Enter the disease shock, or heart failure. se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Blunt Force Injuries disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Funeral

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Itams 23a

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natural',

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the Medical Examiner must be notified at

Director

Completed by Funeral

Be

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with the Maryland

2 should be filed within 72 hours after death and Mental Hygiene.

Pages 1 and 2 should nent of Health and Men

Health

itam 2

Department of Important: If it any injury or o once.

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records.

Division of Vital

sician and burial-transit The law requires that the death certificate be executed the as use į the ģ certificate has page 2 Hospital or Atlanding Physician: this

After 1

Director:

24 hours a

within 2 To tha

death.

Physician/Medical by Completed Be P Certification:

Examiner

25. Was case referred to medical examiner? 27. Manner of Death

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 XUnknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 🗆 No

1 Yes

1 Natural

2 Accident

3 🗌 Suicide

4 X Homicide

29a. Certifier

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4 Pregnant at time of death

28a. Date of Injury Found June 14, 2006

9 Unknown

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

3 Ectopic pregnancy 5 Other (specify)

24a. Was an

26. Place of Death (Check only one)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Dav

Year

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2□No 1 Yes 2 □ No

23d. Date of delivery

Month

Other: 4 Nursing Home 5 Residence 6XX Other (Specify) Scene 28d. Describe how injury occurred

Subject assaulted 28l. Location (Street and Number or Rural Route Number, City or Town, State)

415 Cakington Road, Havre de Gracemd

June 15,2006

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 XNo

29d. Date signed (Month, Day, Year)

O.C.M.E.

Field

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

28b. Time of

Found p

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

32 Registrar's Signature JUN 2 2 2006

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 5, 2006 Year **Physician** Alfred Pulley 12:31 P M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Southern Maryland Hospital Clinton 1 Prince George's Months Days Hours Min. Oct. 27, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⋤M 2□F North Carolina Yrs. Director 466-42-6647 79 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√ No Maryland Prince George's Temple Hills Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4205 Blacksnake Drive 20748 USA deeth . Funeral 12. Was Decedent Ever in U.S.
Ammed Forces?
KGYes 2 D No
ITYES, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritat Status filed within 72 hours after 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛠 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) Coltege (1-4or 5+) Master Sgt. USMC Military 1 permit. Peges 1 and 2 should be filed v Deperment of Health and Mental Hygie important: if item 27 is marked other til eny injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Luther Pullev Mollie Wiggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie H. Pulley / Wife 4205 Blacksnake Drive Temple Hills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery June 29, 2006 Arlington, Virginia 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) NEUMONIA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) been signed by the eshould be detached to 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 🗆 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 ☑Natural 28b. Time of 28d. Describe how injury occurred 5 Pending Director: A 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING D52900 06-200 6 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8700 CENTRAL AU H 301 LANDOUGR MD 20785 MO MOMOH 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar JUN 0 7 2006

DHMH 17 Rev 1/2001

Amend. # 19a per FH June 7, 2006 AACo. GSR 1 _ For

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental	Hygien
Certificate of Death	Reg N

		-
4	#	1
	Physician	
	/Medical	_
	Examiner	4

Fun

Dire permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospitei or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

	•	for State Registrar	State of Mic	ar y tarre		tificate of		ina mon	F	Reg. No.	200	6 1	9810
Jan Jan		1. Decedent's Name (First, Middle, Las	st)						Date of Dea Month				ime of Death
ysicia Aedic		Mary Joan Paupe							une 4	, 20	06	_ 11	L:55 A ^M
amin	er	4a. Facility Name (If not institution, give				4b. City, Town,		Death			County of De		
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=		10a. State 10b. County		10c. City,	, Town or Lo	cation						10d. Ins	side City Limits
100	ţō	Maryland Anne Art	ınde1	Crof	ton							1 🛭	ŽYes 2□No
noti	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What	Country?	
a pe	al D	1609 Foresthill (Court			21114				USA			
1	Funeral I	11. Marital Status	12. Was Decedent 6 Armed Forces?	Ever in U.S	3. 13. \	Vas Decedent of Yes, specify Cul	Hispanic Origi	in? (Specify Puerto Rica	Yes or No-	. 1	4. Race - Al Black, W		ian,
any injury or other traumatic event, the Madical Examinat must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 ☐ Yes 2 XX If Yes, Give Year or Dates:	No		☐ Yes 2 No			,	1	Specify: W		
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9 0	Be c	James T. Coyle	7					erine					
mati	To	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Address (Stree						a, Zip Code)	
rtrau		Heike Kesecker/-	Daughter 1	nieœ	6224	Waterlo	o Road	Colum	bia,	MD 2	1045		
othe		20a. Method of Disposition				sition (Name of natory or other pl		Date			cation - City	or Town, St	ate
ry or		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				ematory		06/07/	2006	Wa1d	orf,	MD.	
any inju once.		21. Signature of Funeral Service Licer	nsee			. Name and Add							Iome
# G		> ft Kuc	- Ky		16	6000 Ann	apolis	Road	Bowie	, MD	2071	5	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin	ne			_			rest,		Interv	oximate ral Between
cian		Immediate Cause (Final disease or condition	a acus	e mi	40 Ca	rdial	infar	chon				Orise	t and Death
lical iner		resulting in death)	Due to (or as	a consequ	ence of):	1 -1		0					
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as tha burial-transit		(d				····						
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r use	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregnan	су			2	3d. Date of	-	Von
hed fo	Physician/	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregnant at 9□ Unknown	time of de	ath 5	Other (specify)					MOULL	Day	Year
detac		Part II. Other significant conditions of	contributing to death b	ut not resu	Iting in the u	nderlying cause o	ven in Part I.		23e. Did to	bacco u	se contribute	to the caus	se of death?
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lor, p	0	25. Was case referred to medical	3(01)				26. Place o	of Death (CI	1 ☐ Yes		101	es 2 N	0
direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatien	t 3 DOA	thor				☐Other (S	pecify)	
neral		27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Inju (Month, Day	ry y Year)	28b. Time of Injury	28c. Inj	ury at ork?	28d.	Describe h	ow injury	occurred		
he fu	catle	2 Accident Investigatio	in				∃Yes 2□N	lo					
d in by	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju- building, et	ury - At hor c. (Specify,	me, farm, str)	eet, factory, offige	Ð	28f.	Location (S City or Tow	Street and m, State)	d Number or	Rural Route) Number,
completely filled in by the funeral director, pege 2 should be detached for use	Medical (29a. Certifier 1. Certifying Pl (Check only 2 Medical Example)	hysician: To the best miner: On the basis of and manner st	f examinati	vledge, deatl ion and/or in	occurred at the vestigation, in my	time, date and opinion, death	place, and occurred a	due to the o	ause(s) date and	and manner place, and c	as stated. lue to the ca	łuse(s)
сошр	Me	29b. Signature and title of certifler					nse number				signed (Mo		
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		30. Name and address of person who	completed dause of d	leath (Item	23a) (Type Med	Print) PKI	of Si	ute	520	Ar	UNAPO	-13 A	10
Sta egisti		31. Date filed (Month, Day, Manual)	9 7 2006 egist	Signat	ure &	Morte							

06-04184 Mary Ritchie

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 2200 hrs Medical Examiner June 16, 2006 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Memorial Hospital Cumberland Allegany If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Director M 2 X F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits 28a-f show 1 Yes 2 No it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rtment of Health and Mental Hygiene. Director 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country 23a Funeral Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Married Yes 2 X No Give Year Widowed Divorced Yes 2 No specify: Specify: "natural" þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surr marked ic event, Be ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ruyal Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 Cremation crematory or other place) 3 Removal from State Important: 1 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Home, P.A. Dearpelli mhorland Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician failure. List only one cause on each line Between Onset and /Mindical Death a. Complications of hip fracture Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed ling physician and as the burial - tran Physician/Medical UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Year 2 past 12 months? Pregnant at time of 5 Other (Specify) 1 Yes 2 🗸 No 9 Unknown Unknown q s been signed by the s should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has performed? ✓ Yes 2 1 🗸 Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 ✓ Inpatient 2 Other₄ this ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) May 6, 2006 After 1 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Subject fractured hip, had repaired, reinjured 1 0000 hrs Natural Yes 2 V No Director: d in by the f Pending hours after death. (dislocated) and bled during surgery 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town State Memorial Hospital, Cumberland, MD (Specify) Nursing Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 18, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month. 32 Registrar's Signar State 2006 SERVINGE S Registra

DHMH 17 Rev 1/2001 OCMF 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Angelo Michael Robsco 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Year 0340 hrs June 11, 2006 Medical Examiner MICHAEL RABASCO ANGELO Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Indian Charles 2720 Marshall Hall Road If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min Director 219-02-2979 PRIL 1,1983 Country) MD 23 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City. Town or Location 10a. State 1 YYes 2 No 28a-f show MARYLAND CHARLES INDIAN HEAD notified at once. Director 10f. Zip Code 10g. Citizen of What Country' 10e. Street and Number 3250 GREEN MEADOWS DRIVE 20640 U.S.A. 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 XNever Married 2 Married Yes 2 X X No WHITE after If Yes, Give Year Yes 2X X No specify Specify Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours: nent of Health and Mental Hygiene. ant: If item 27 is marked other than "naturn or other traumatic event, the Medical Exami Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 R&R CONTRACTORS WELDER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be RHODA FROCK MICHAEL JOHN RABASCO, III 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL J. RABASCO,III-FATHER 3250 GREEN MEADOWS DR., INDIAN HEAD, MD20640 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Important: injury or oth TRINITY 6-16-06 Department MEMORIAL GDNS. WALDORF, MARYLAND Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO RAYMOND FUNERAL SERVICE, P.A. Do not enter the mode of dying, such as eardisc or respirator ares. shock, or heart Approximate Interval 23a. Part I. Enter the disease, or complications hat caused the death. **Physician** Between Onset and failure. List only one cause on each line /Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician/Medical X AMENDED 1,4 per meo g856 6-22-06 vt UNPENDED Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Live birth Month Dav Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 Unknown Completed certificate has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 V Yes 26. Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: of Vital Be Other₄ examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 🗸 Yes ဥ 28a. Date of Injury (Month Day Year Jun 11, 2006 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Driver auto fixed object collision within 24 hours after uc.....

To the Funeral Director: A 0301 hrs Division Natural 1 Yes 2 V No 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 ___ Suicide Could not be or Town. State (Specify) Local Street determined 2720 Marshall Hall Road, , MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

31. Date filed (Month, Day Year) 2006

Name and address of person who ompleted cause of death (Item 23a)

29b. Signature and tit/a of certifier

Susan Hogan MD.

Assistant Medical Examiner egistrar's Signature

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 11, 2006

Registrar

			For Stete Registrar		State o	of Mary	/lanc				lealth a		lental F	lygien Reg. N	7. UUt	19	813
ý,	Physici		1. Decedent's Name (First, Mi Mary Augusta										2. Date of Month June	. 0	eay Year	3. Time of 9:25	f Death
	/Medio Examin	- 41	4a. Facility Name (If not institu			mber)			4b. City,	Town, or	Location of	of Death		4	c. County of Dea	ıth	
40			Lorien Nursin	g Hon	ne					umbia				H	loward		
	Funeral		5. Social Security Number	6. Sex	м Ж	7. Age (li	-	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month,	Day, Yea	r) C	thplace (State ountry)	
***	Director		235-40-0712 Usual Residence of Decedent				96	115.					08/29	9/190	9 West	t Virgi	nia
	land ow		10a. State 10b. Cou	nty		10	c. City,	Town or Lo	cation							10d. Inside C	ity Limits
	Mary Mary	to	WV Harr	ison		c	lar!	ksburg	Ţ							1X Yes	2 🗆 No
	r 288	irec	10e. Street and Number						10f. Zip	Code				10g. C	itizen of What C	ountry?	
	th wit	ai	212 Walnut St	reet					26	301				USA			
	eep .	Funeral Director	11. Marital Status		12. Was Dec	edent Eve	r in U.S	13.	Was Dece	dent of Hi	ispanic Ori in, Mexican	igin? (Sp	ecify Yes or Rican, etc.)	No-	14. Race - Am Black, Whi		
36	or It	by Fu	1 Never Married 2 N		1 ☐ Yes If Yes, Gi Year or D	2 X No ve			1 🗆 Yes		Specify:				Specify:		
21215-0036	buid be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "naturel", or Items 23a or 28a-f ehow artic event, the Medical Exertian must be rutilled at	d be	3 X Widowed 4 □ Divore	ent's Edu		ates:		16a. Dece	dent's Lleu	al Occupi	ation			16h	Kind of Business	ite	
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2	t Hyg other	BeC	17. Father's Name (First, Midd	le, Last)							18. Mothe	er's Name	First, Mide	dle, Maide	en Sumame)		
<u>la</u>	Ald be Alenta	To B	Frank A. Oli	verio)						Ange	la M	arie S	Spada	fore		
Maryland	and h		19a. Informant's Name/Relate	onship (Ty	rpe, Print)			19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	Aoute Nu	mber, City	or Town, State,	Zip Code)	
	and 2 ealth n 27		Carmen Romano	/ Sor	1									- +	outh Car		29928
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "naturel; or Items 23a or 28a-1 ehow apprintury or other traumatic event, the Madical Experiment must be intilled at ODGE.		20a. Method of Disposition 1 X Burial 2 ☐ Crematic	n 3 □F	Removal from	State	20b. Pla	ace of Dispo metery, crei	natory or o	me of other plac	(8)	- [Date	20c.	Location - City or	Town, State	
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Baltimore,	Depar Impor Impor eny in		21. Signature of Funeral Serv	ce kicens	e			- 1							ns Fune		3
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9	death certificate be executed te attending physician and of for use as the burial-transit	Physician/Med	IF FEMALE:														
Вох	leath certific attending pi	lan/	23b. Was decedent pregnant in the past 12 months?	2		birth 2	Fetal	death 3[Ectopic p						23d. Date of de Month		Year
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α,	that the de ned by the a detached f	P	Part II. Other significant cond	litions cor	ntributing to d	leath but n	ot resul	ting in the u	nderlying o	ause give	en in Part I		23e. D	id tobacco	use contribute t	o the cause of c	leath?
Records,	uires tha signed l id be det	d by											11	Yes	2 □ No 3 □ P	robably 4 🔀	Jnknown
Ö	w require been sig should b	Completed											24a. W	ns an	24h Were a	utopsy findings	available
Re	he lav	ш					-						au	utopsy erformed? s 200	prior to	completion of c	ause of
Vital	icien: Th certificate rector, pag	e C	25. Was case referred to med	ical						_	26 Place	of Death	1 Ye		lo 1 Yes	2 □ No	
>	Physicien: The law requires that the this certificate has been signed by the fall director, page 2 should be delached.	ToB	examiner? 1 ☐ Yes 2 ◯ No		lospital:	Inpatient	2□E	:R/Outpatier	nt 3 🗆 D	OA Oth	00				6 ☐Other (Spe	ocify)	
0	ig Physiter this neral dir		27. Manner of Death		28a. Date	of Injury oth, Day Ye	aar) a	28b. Time o	1	28c. Injun Worl		- 1			ury occurred	- //	
į	uttendin death. ctor: Af y the fur	atic	20,100.00	stigation		,,	/	,,	М		Yes 2	No					
Division of	il or Attending after death. I Director: Afte d in by the fune	Certification:		ild not be ermined	28e. Plac build	e of Injury ling, etc. (S	- At horn Specify)	ne, farm, sti	eet, factor	y, office			28f. Location City or	n (Street a Town, Sta	and Number or R te)	urai Route Num	ber,
Ω	urs af urs af oral D	Ce		e de la companya de l				VEGETATION TAIL		ere and and	vantura tura	18116-2016			ar november of the com-	100000000	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	dicai	(Check only 2 Medione)	al Exami	ner: On the b	asis of ex nner stated	amınatio	on and/or in	vestigation	i, in my of	pinion, dea	ith occurr	ed at the tim	ne, date a	s) and marrier a nd place, and du	e to the cause(s	.)
	ithin ithe	Me	29b. Signature and title of cer	ifier	ΛΛ.	1 0			29	c. License	e number			29d. D	ate signed (Mon	h, Day, Year)	
	~ s ⊢ ō		> Dlo-	la 1	Hli	r la	Q IA	M	D	T	11	33	72	T	une-	051	not
•			30. Name and address of pers	on who co	ompletęd cau	se of death	h (Item :	23a) (Type.	Print)	110	oT.	NA.	11	7	VIIAA	111	000
			10820	# 3	ckr	ru	R	ida	e R	100	2	LAT	TIL	Thir	5-434	05,2	44
1,3	Sta	ite	31. Date filed (Month, Day, Ye	ar)	7 2006	Regis ar's	Signatu	ILO T	dea	AL S	911		- (V 	(-1)	1111		77
	Regist	rar		11 U	CAND	U 36		100	A STATE OF								

			For State Registrar	State of M	arylan		artment tificate			and Me		jiene 006	198	14
	Physici		Decedent's Name (First, Middle, La Maureen Rossow	st)							2. Date of Dea Month June	7, Day 2006 Year	3. Time of 4:55	Death A M
	/Medic Examin		4a Facility Name (If not institution, given Citizens Care & R	·		Center	4b. City, T		Location o	of Death		4c. County of Dea		
	Funeral Director		227-00-1713	Sex 7. Ag 1 ☐ M 2 🛣 F	90 (In yrs. I 61	last birthday) Yrs.	If Under 1 Months	Days	If Under : Hours	Min	8. Date of Birth (Month, Day IOV • 17	, Year L. L. C	thplace (State o ountry) nesota	r Foreign
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo							10d. Inside Cit	
	death with the Maryland me 23a or 28e-f ehow Frivat by rightland at	Director	Maryland Freder:	ick 		Fre	deric		_		1	0g. Citizen of What C	1 X Yes	2 No
	3a or	בוֹם	1001 Carroll Park	way, Apt.	319		101. 210	217	701			United St	•	
136	d within 72 hours after death glene. In then "natural", or Iteme 2 the Madical Examinat mu	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 M If Yes, Give Year or Dates:	Ever in U.		Was Decede f Yes, specif		spanic Origin, Mexican	gin? (Spec i, Puerto R	ify Yes or No- lican, etc.)	14. Race - Am Black, Whi		
215-0036	within 72 hou ene. then *natura	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or	5+)	16a. Deced (Give life. L	dent's Usual kind of work DO NOT use	Occupa done d retired	ation Juring most	t of working	g	16b. Kind of Business	/Industry	
7	filed wit Hygiene other the		12			Nursi	ing Co	mpai			45° > A 6° 4 8° -	Geriatric	Care	·
Maryland	9 7 5	To Be	17. Father's Name (First, Middle, Last Rudolph Rossow)							rist, Middie, i neider	Maiden Sumame)		
Mary	12 should I h and Meni 7 is marke reumatic	-	19a. Informant's Name/Relationship	•	,							City or Town, State,		701
Baltimore, I	Pages 1 end 2 should been of Heatth and Mentint if Item 27 is marked ity or other treumatice		Judith Rossow / 20a. Method of Disposition 1 Burial 2 SCremation 3	Removal from State		lace of Dispo emetery, cren	sition (Name natory or oth	e of her place	9) 1	June	e 8,	Frederick 20c. Location - City or	Town, State	
altır	permit. Pages Depertment of I Important: If Ite any injury or of		4 □ Donation 5 □ Other (Special 21. Signature 1 Ineral Service Lice		Res	thaven				200		Frederick, Skkot Coo		ıd
ñ	F 5 6 6		1/1/1/			95	01 Ca	toct	in M	tn. H	wy. Fre	ederick, M	21701	
	Physician		23a. Part Filer the disease or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	C	d the death ine. Verna	0	er the mode		g, such as	cardiac or	respiratory arm	est,	Approximate Interval Between Conset and E	ween
- 6	/Medical Examiner			Due to (or as	a consequ	ueoce of):		1						
	ate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as				•						
09/89	icate be e physicien s the buria	Ical	· ·	_ d.										
O. Box	the death certifical y the ettending phi ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 2 No 9 ☐ Unknown	23c. If yes, outcome 1☐Live birth 4☐Pregnant a 9☐Unknown	2 Fetal	death 3	Ectopic pre Other (spe					23d. Date of de Month		/ear
Records, P.	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions Cerefy met	contributing to death to	out not resu	10 0	fung car	-	en in Part I.		23e. Did tol	bacco use contribute to es 2 □ No 3 □ P		
	The lar ate has page 2	Completed					0					y prior to death? 2 No 1 ☐ Yes	utopsy findings a completion of ca	available ause of
Vital	Physician: rthis certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 🗍	ER/Outpatien	t 3 DO	Othe	A .		(Check only on e 5 ☐ Reside	e) ence 6 □Other <i>(Spe</i>	cify)	
Division of	Attending Physician: It death. ector: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 Pending Accident investigation		iry iy Year)	28b. Time of Injury	28 M	C. Injury Work		28		ow injury occurred		
DIVIS	i grad	Certification:	3 Suicide 6 Could not I 4 Homicide determined	28e. Place of Inbuilding, e	jury - At ho tc. <i>(Specif</i> y	ome, farm, str	eet, factory,	office		28	8f. Location (SI City or Town	reet and Number or R n, State)	urai Route Numi	ber,
	he Hospitel in 24 hours he Funaral I pletely lilled	edical	29a. Certifier Certifying P	hysician: To the best miner: On the basis of and manner st	of examinat	wledge, death tion and/or inv	occurred a vestigation, i	it the tim in my op	e, date and pinion, dea	d place, ar th occurred	nd due to the ca d at the time, d	ause(s) and manner a ate and place, and du	s stated. o to the cause(s))
)	To the within 2 To the complex	Σ	29b. Signature and title of centrier	farfn	an			-	number -/39	71	2	9d. Date signed (Mont	h, Day, Year)	
	5		30. Name and address of person who			100	Print)				WD 01=	1//01	1	
		ate	Robert L. Kaufman 31. Date filed (Month, Day, Year)	32. Revist	rar's Signa	9th S			reder	ick,	MD 2170	U1		
4	Regist	rar	و به سالهاند	5000		N A	and the							

			1 - For State Ragistrar	State of Ma	-	epartmen Certificat			ınd Mer		giene Reg. No.	006	19815
			1. Decedent's Name (First, Middle, Last)						2.	Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		ANNE MAE	REALE					/	May	22,2		0850 M
1	Examin		4a Facility Name (If not institution, give	street and number)	1 . }		Town, or	Location o			4c. Co	unty of Death	^
			Coastal Hospic				all-	S b u			0		mico
	Funeral		5. Social Security Number 6. Security Number 169-12-3737	7	(In yrs. last birt	thday) If Under Months	Days	If Under 2 Hours	Min.	Date of Bin (Month, Da	ıy, Year)	Cou	
	Director		Usual Residence of Decedent		0.5				MAY	L 11,	1921	PEN	NSYLVANIA
	land ow		10a. State 10b. County		10c. City, Towr	or Location							10d. Inside City Limits
	Man -feh	ţ	MARYLAND WICOM	ICO	SAL1	SBURY							Yes 2 No
	ith the Marylar or 28a-f ehow	lrec	10e. Street and Number			10f. Zip	Code				10g. Citizen	of What Cou	ntry?
	23a c	Funeral Director	1110 HEALTHWAY	ROAD			2180	04			AM:	ERICA	
	ter dea	iner	11. Marital Status	12. Was Decedent Ended Forces?		13. Was Dece If Yes, spe	dent of His	spanic Orig	gin? (Specify , Puerto Ric	y Yes or No an, etc.))- 14.	Race - Amen Black, White,	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes	2 X No	Specify:			Sp	ecity: WH	ITE
21215-0036	72 hours after death with the Maryland "neturel", or tlems 23s or 28s-1 show idical Examiner must be multified at	d b	3 Widowed 4 □ Divorced 15. Decedent's Edu		162	Decedent's Usua	al Occupa	tion			16h Kind	of Business/In	idustry
15	n 72	olete	(Specify only highest grade	e completed)		(Give kind of wo	rk done di	uring most	of working		IOD. KIIIG	51 D03111 0 33711	idustry
12	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	.)	HOMEMA	KER				DOI	MESTI	C
	illed Hygir other	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (F	irst, Middle,	, Maiden Sui	mame)	
<u>a</u>	should be filed withir and Mental Hygiene. marked other than imatic event, the M	To B	UNKNOWN M	ILLER				U	NKNOW	/ N			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23s or 28s-f eho other treumatic event, the Medical Examiner must be routilled at	'	19a. Informant's Name/Relationship (Ty			. Mailing Address							
	1 and 2 Health em 27 ther tr		JASON M. REALE	- GRANDS		3770 JC		ON R					
ore	ges 1 t of H if iter or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	lemoval from State	STremeter	Disposition (Nation (Nation)	ne of ther place) is	Date / 27 / C			ion - City or T	
Ě	Pages ment of tant: If it		4 □Donation 5 □ Other (Specify)			IETERY			/27/0				DELAWARE
Baltimore,	permit. Pages 1 a Department of Hee Important: If Item eny injury or othe		21. Signature of Fuheral Service/Ligens	Cates					S FUN LAWAR			E, INC	.
			23a. Part1. Enter the disease, or compleshock, or head failure. List only or	ications that caused the	the death. Do r				cardiac or re	spiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (F) al disease or condition	Alah	O mer	$\dot{s} = D_{\lambda}$	cen	e					Onset and Death
1	/Medical		resulting in death)	Due to (or as a	consequence		J						
	Examiner		Sequentially list conditions,	o									
	od sit	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):							
	and P-tran	хап	that initiated events resulting in death) Last	Due to (or as a	consequence	of):			-				
8760,	certificate be executed Iding physician and Ise as the burial-transit	Ical Examiner	L.		·	,							
687	ficate phys s the			J									
Box (certif nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o							23d	. Date of deliv	ery
ă	death of atten	cla	in the pact 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 □Ectopic p 5 □ Other (sp						Month	Day Year
P.O.	t the c by the ache	hys	9 □ Unknown	9□ Unknown									
	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit		Part II. Other significant conditions con	ntributing to death bu	t not resulting in	the underlying	ause give	n in Part I.	L Addition	23e. Did t	obacco use	contribute to t	he cause of death?
ğ	- v -	ed	Renal 1	a luce	7					1 🗆 `	Yes 2	lo 3 ☐ Pro	bably 4 □Unknown
Records,		plet								24a. Was		4b. Were auto	opsy findings available ompletion of cause of
Ř	hysicien: The law his certificate has b I director, page 2 si	Completed by									rmed?	death? 1 ☐ Yes	2010
Vital	artifica ctor,	Be	25. Was case referred to medical examiner?						of Death (C	heck only o	one)		-
of V	Physicien: this certific ral director,	ဥ	1 □ Yes No	lospital:				4 🗆 190				Other (Speci	fy)
Ē		- CO	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. 1		28c. Injury Work			l. Describe l	how injury or	curred	
sio	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be	OO - File on of Iniv	- Athama (a	M		/es 2 □ l		Logation /	Stroot and M	umbos os Pus	al Route Number.
Division	or All	Certification:	4 Homicide determined	28e. Place of Inju- building, etc.		irm, street, ractor	у, опісе		201	City or To	wn, State)	amber or nor	ar Houte Number,
1	To the Hospitet or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Ö	29a. Certifier Certifying Phy	sician: To the best o	f my knowledge	e, death occurred	at the tim	e, date and	d place, and	due to the	cause(s) and	d manner as	stated.
	24 h	Medical		ner: On the basis of and manner stat	examination an								
	To the vithin 2 To the comple	Me	29b Signature and title of certifier	0/1	/	29	c. License	number			29d. Date s	gned (Month,	Day, Year)
		(12 ()2 (20	CHM		Da	162	178		5	-22	-06
	Da		30. Name and address of person who co	ompleted cause of de	ath (Item 23a)	(Type, Print)				P 1			_
_	00		Doubt Carell MO	Costof H	spie	PO BO	x 17	33	Si	1.5	MD	21	902
		ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					J	*		
	Regist	rar	.!!!N 0 8 2	006	- M	March	,						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra 006Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:20 AM PHYLLIS J. RAINBOLT June /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner room 8. Date of Birth (Month, Day, OCt. 16, 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Year) 927 Months Days Min. Hours Kansas Yrs 78 524-56-3215 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f ehow other traumatic event, the Madical Examiner must be notified at Maryland Somerset Pocomoke City 1 ☐ Yes 2 XNo Directo 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with 0 21851 U.S.A. 32832 Rehobeth Road or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █️No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 21X Married White 21215-0036 1 ☐ Yes 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced Year or Dates "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) then. 12 should be filed within h and Mental Hygiene. 7 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Merchandiser Greeting Cards 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland Be Edith Chevron William Earl Maus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum 32832 Rehobeth Road - Pocomoke City, MD 21851 Mary Rainbolt (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 6/10/06 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signatur Prin, ru 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD Robert H. Bradshay Jr 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASUND **Physician** /Medical Due to (or as a consequence of): Examiner Demontin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physicien Completed by Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy ō Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be 2 ☐No 3 ☐ Probably 4 ☐Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. hours after death uneral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral E 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and class and due to the course(s) and maynor as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 147074 June 9, 2006 NUMBL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0415 5- DIVISION 5) - SALISBURY MA 21801 NATESAN VEL 31. Date filed (Month, Day, Year) State JUN 1 3 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar		Sta	ate of M	larylan		artment of h			lental Hy		000	100	17
			Registrar 1. Decedent's Name	First Middle	l ast)			Ce	tillcate of	Dealli		2. Date of D	Reg. No.	UUD	3. Time o	f Death
н	Physici		Rose	Ett	,	Su	mmer	ford				June Month	15	2006 Year	8:30	P.M
14.00	/Medic Examin		4a. Facility Name (If r					LOLU	4b. City, Town, o	or Location	of Death	ourc		County of Dea		
		ei	206 Pion				•			Depos				ecil		
	Funeral		5. Social Security Nur		. Sex	7. A	ige (In yrs. i	last birthday)	If Under 1 Year Months Days	If Under		8. Date of B	irth	9. Bir	thplace (State	or Foreign
	Director		260-23-4		1 □ M :	2XIVF	44	Yrs.	WOTHIS Days	nours	Willi.	10/15	761	West	Virgi	nia
	pur *		Usual Residence of D 10a. State	ecedent 10b. County			10c. City	y, Town or Lo	ecation						10d. Inside C	ity Limits
	daryli f sho	ō	MD		cil			rt Dep								2 X No
	the t	rec	10e. Street and Numb		CII		10	it be	10f. Zip Code				10g. Citiz	en of What C	ountry?	
	be filed within 72 hours efter deeth with the Maryland ital Hyglene. id other than "natural", or items 23a or 28a-f show event. The Medical Examiner must be notilied at	Funeral Director	206 P	ioneer	Ridge	e Driv	re		2190	4			U	.S.A.		
	deetl	ner	11. Marital Status			as Deceden		S. 13.	Was Decedent of I	Hispanic Or	rigin? (Spe	ecify Yes or N	0- 1	4. Race - Ame Black, Whi		
9	or its	F	1 Never Married		1	☐Yes 2 🔀 Yes, Give			1 ☐ Yes 2X No					Specific		
21215-0036	ural',	d by	3 ☐ Widowed 4		Y	ear or Dates	:	16a Dana	death Herel Occ					WI	nite	
15-	n 72	Completed	(Specify	5. Decedent's only highest	grade com	npleted)		(Give	dent's Usuai Occuj kind of work done DO NOT use retire	durina mos	st of worki	ing	16D. KI	id of Business	rindustry	
12	filed withi Hygiene. Ither than	E O	Elementary/Second	lary (0-12)		ollege (1-4or 4	r 5+)		ers Assi				Boar	rd of I	Education	on
	e filed I Hygi other	Bec	17. Father's Name (F	irst, Middle, La	ist)					18. Moth	er's Name	(First, Middle	. Maiden	Sumame)		
/lar	should be filed nd Menta! Hygi marked other umatic event, I	To E	George H	erbert	Elmo	re				G	Glady	s Mari	e Joh	nston		
7	2 2 2 2		19a. Informant's Nam		-		\		ng Address (Street							
	1 and 2 Health tam 27		David B.		iora	(Spou			Pioneer 1	Riage		Port				t
lor	Pages 1 ar		20a. Method of Dispo	Cremation 3		al from State	e c	emetery, cre	matory`or other pla					cation - City or		
Baltimore,	perriit. Page Depertment o Important: if any injury or once.		' 4 ☐ Donation 5 21. Signature of Fund				R.		ris & Co		6/19/			Cheste	r, PA	
Ba	permit. Page Depertment of Important: if any injury or once.		Vust	in An	uf	mai	esse	l T A	arring-C berdeen,	argo 1 Mary	Funer land	al Hom 21001	e, P.	A.)		
			23a. Part1. Enter the shock, or heart	disease, or co failure. List or	omplication	ns that cause use on each	ed the death line.	n. Do not en	er the mode of dyi	ng, such as	s cardiac c	or respiratory	arrest,		Approximat Interval Bet	ween
	Pnysician		Immediate Cause (F disease or condition	inal	a	2	Bran	- Me	tantuse	7					Onset and	-05
	/Medical Examiner		resulting in death)	1		Due to (or a	s a consequ	ueno of):	0 4						100	
		<u></u>	Soquentially list cond if any, leading to imm cause. Enter Underh	Miont,	b	Due to (or a	s a consequ	Phoe of):	lung						12-1	1-05
8	nsit	i i	cause. Enter Underly Cause (Disease or in that initiated events	ying		200 10 (0. 2			V							
5	be executed sicien and burial-transit	Examiner	resulting in death) La	st	c	Due to (or a	s a consequ	uence of):								
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99	ntifica ng ph as th	P	IF FEMALE:							A-4750, 75 k 3 k						
Вох	leath certifica attending ph i for use as t	Physician/M	23b. Was decedent p		1	yes, outcom □Live birth	2 Fetal	Ideath 3	Ectopic pregnanc	у			2	3d. Date of de Month	,	Year
o.	the a	/sici	1 ☐ Yes 2 🛣			□Pregnant: □Unknown	at time of de	eath 5[Other (specify)					141011111	24,	
σ.	that the ded by the detached	P	Part II. Other signific	ant condition	s contribu	ting to death	but not resi	ulting in the u	nderlying cause gr	ven in Part I	I.	23e. Did	tobacco us	se contribute to	the cause of c	death?
Records,	uires tha signed Id be del	d by										1 🗆	Yes 2	No 3□P	robably 4 🗍	Jnknown
00	w requir been si should	jete										24a. Wa	s an	24b. ₩ere ai	utopsy findings	available
Re	sician: The law s certificate thas b lirector, page 2 s	Completed											ormed?	prior to death? 1 \(\sum \text{Yes}\)	completion of a : 2□ No	ause of
		0	25. Was case referre	d to medical						26. Place	e of Death	(Check only		1 🗆 103	20110	
\		ToB	examiner? 1 ☐ Yes 2 💢 N	0	Hospit	1 🔲 Inpai		ER/Outpatie	nt 3□ DOA Ott	her: 4□Ni	ursing Ho	me 5 Res	idence 6	□Other (Spe	cify)	
			27. Manner of Death	5 Pending	28	a. Date of In (Month, D	jury Jay Year)	28b. Time o Injury	f 28c. Inju Wo	ry at rk?		28d. Describe				
Sio	r Attending er death. rector: Afte by the fune	cati	2 Accident	investiga 6 ☐ Could no	t bo]Yes 2□						
Division	or At after Direc in by	Certification:	4 Homicide	determin		building,	njury - At no etc. <i>(Specif</i>)	ome, farm, sti	eet, factory, office		1	City or To	wn, State)	Number or H	ural Route Num	ber,
_	spital cours rerai		29a. Certifier 1	★ Certifyina	Physician	n: To the bes	st of my kno	wiedge, deat	h occurred at the ti	me, date ar	nd place.	and due to the	cause(s)	and manner as	stated.	10
	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 one)	Medical Ex	caminer: (On the basis and manner s	of examina stated.	tion and/or in	vestigation, in my	opinion, dea	ath occurre	ed at the time	date and	place, and due	to the cause(s	
	To the To the comp	Σ	29b. Signature and ti	tle of certifier	0.	1			29c. Licens	se number			29d. Date	signed (Mont	h. Day, Year)	
)	Q.		1 de	1	Xo	Mn	~ 20)		CI	OTOC	362	ス	01	16/06		
	V		30. Name and address	amii	MO	ted cause of	death (Item	123a) (Type.	Print) Star	ton K	ed &	Sk 200	Ne	wak	DE K	1713
	Sta		31. Date filed (Month		one	32 Regis	trar's Signa	ture 1	aste)							
	Registi	ar	JL	IN 2 2 2	מטט,	13.84	Sie Sie	100								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 16 Day 2006 Year 8:10 AM M Albert Woodrow Schultz, Sr. June **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 8830-A Yellow Springs Road Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 1, 1947 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 1 ⊈M 2 ☐ F Mary Tand 89 214-10-2028 Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location i Health and Mental Hygiene. Itsm 27 is marked other then "natural", or Items 23a or 28a-1 ehov other traumatic svent, the Mucical Examinar must be notified at Frederick Frederick 1 ☐ Yes 2 No Maryland Directo 10e. Street and Number 8830-A Yellow Springs Road 10f. Zip Code 10g. Citizen of What Country? with 21702 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 ☐ No White Specify: Specify: 3€XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinest U. S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Conrad Schultz Isabelle Hildrebrand ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8830-B Yellow Springs Road, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) Christine R. Baer, Daughter 20b. Place of Disposition (Name of competery, crematory or other place)
Rocky Springs Cemetery 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State permit. Pages of Depertment of H Important: If its any injury or ot June 20, 2006 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury f Funeral Service Licenses 22. Name and Address of Facility Keeney and Basford PA Funeral Home 40*0*021 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCLEROTIC HEART DISEASE **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy ğ Year Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide rc Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) Fo the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 2170/ 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 JUN 2 2 Registrar

06-03875 Eugene Conroy Scott

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

agono como,		1-For State Control of He Registrar Certificate of De	•		g No. 200	6 1981
Physici		Decedent's Name (First, Middle,Last)		Date of Death Month		3 Time of Death
ledical Exami	ner	ragene don't bedet, br	T	June 6, 200	06	2129 hrs
			y, Town, or Location of Death everly		4c. County of Deat Prince George	
Funeral			nder 1 Year If Under 24Hrs.	8 Date of Birth	h (MM/DD/YYYY) 9 Bii	thplace (State or
Director		577-74-2529 1X M 2 F 50 Yrs. Mc	nths Days Hours Min.	06/23,	/1955 Foreig	ountWash., DC
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d Inside City Limits
ž .			itol Heights			1 X Yes 2 No
daryland 28a-f show 1 at once.	Director		Zip Code	100	g. Citizen of What Cou	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of stellath and Mouted Hyge within 72 hours after death with the Maryland wit. If tiem 27 is marked other than "natural", or items 23a or 28a-f she in it. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Ö	6811 Pepper St.	20743		United	States
th with	Funeral	1 Never Married 2 Married Armed Forces? If Yes, sp	edent of Hispanic Origin? (Spe ecify Cuban, Mexican, Puerto R	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
ter dea		1 X Yes 2 No	2 X No specify:	, , , , ,	Af	rican
ours afi Itural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usu	ual Occupation (Give kind of wo		Specify: And 16b. Kind of Business/	nerican Industry
6 172 hc an "ng cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of	working life. DO NOT use retire	ed)		
5-0036 lled within 7 Hygiene I other than the Medica	omp	12th 17. Father's Name (First, Middle, Last)	Security		Gover	nment
215- e filed ral Hyg sed ou	Be C		18.Mother's Name (
2121: ould be fi. d Mental H s marked	To E	Eugene C. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addri	ess (Street and Number or Ru	ural Route Numb	ssa T. Scot per, City or Town, State	, Zip Code)
e, MD 21215-0036 Hand 2 should be filed within 72 hours al reath and should be filed within 72 hours al riem 27 is marked other than "natural riraumatic event. the Medical Examin riraumatic event.		Linda Booth/Sister 2700	Sassafras Ct.	, Owing	s. MD 207	36
Baltimore, permit Pages I ar Department of Hee Important: If ite		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (rematory or other pla		Date	20c. Location - City or	Town, State
t Pag t Pag tment rtant:		4 Ponation 5 Other Specify: Maryland Vet	erans Cem. 6/1			nham, MD_
Baltimore, MD permit Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat					neral Home	
Physician	-	23a. Par I. Enter the disease, or complications that caused the death. Do not enter the modifule. List only one cause on each line.	001 Benning Rd e of dying, such as cardiac or r	respiratory arres	Wash., DC st, shock, or heart	Approximate Interval
/Medical Examiner		Immedia Cause (Final disease a. Hypertensive atherosclerotic	cardiovascular di	sease		Between Onset and Death
) 		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
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ecuted and - transit		d				
e e e c	/Medical	X unpended X amended item#1,23a,PII,27,per	ME,g857,7/15/06 T	T		
68760, certificate b nding physic se as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	th 3 Ectopic pregnanc	cy	23d Date of delivery Month	yay Year
Box 687 e death certifine the attending ed for use as t	Physician	1 Yos 3 No 9 Hokenya 4 Pregnant at time of death 5 Other (S	pecify)			
O. Bo nat the de od by the etached f		Part II. Other significant conditions contributing to death but not resulting in the underly	ng cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
P.C.	d by	Cirrhosis of liver		1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
of Vital Records, ig Physician: The law require the trib certificate has been sineral director, page 2 should be	Completed			24a. Was an autopsy		opsy findings available ompletion of cause of
Reco	E O			perform 1 V Yes 2	ed? death?	
tal Rection: The certificate ector, page	Be	25. Was case referred to medical examiner? Hospital: I position: 2 FB/Outpatient 3	26 Place of Death (Check on	ly one)		
on of Vital I ading Physician: th. : After this certifi e funeral director,	၉	1 ✓ Yes 2 No ruspital 1 Inpatient 2 ✓ ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury			esidence 6 Other:	
도별교학교	ij	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	od. Describe nov	w injury occurred	
Division tal or Attendirs after death.	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor	ry, office building, etc. 2	8f. Location (Str	eet and Number or Rur	al Route Number, City
Div Hospital of 24 hours af Funeral D	Certification:	4 Homicide determined (Specify)		or Town, Stat	te)	
Divisio To the Hospital or Atter within 24 hours after deat To the Funeral Director completely filled in by the		29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the control of the contro	ne time, date and place, and du	ue to the cause(s) and manner as starte	ed.
To the within 2	Medical	and manner stated.	9c. License number		29d Date signed (Mon	
		(bush Hallan	O.C.M.E.		June 7, 2006	ur, vay, rear)
	ł	30 Name and address of person who completed cause of death (Item 23a)				
			, Baltimore, MD 21201			
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
~ ~	_					

Earl P. Smith

06-03688 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day May 30, 2006 Preston 1517 hrs **Medical Examiner** 4b City Town or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Baltimore City NIA 2801 Harlem Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) **Funeral** oreign Director 212-58-2578 1 M 2 52 30 Usual Residence of Decedent 10d Inside City Limits 10b County 10c City Town or Location Ę Yes 2 No Baltimore MD Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country USA Harlem 21216 2801 Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Drigin? (Specify Yes or No-14 Race - American Indian, Black or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes B Yes 2 No specify: If Yes, Give Year Specify Widowed Divorced traumatic event, the Medical Examiner ş or Dates 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Construction If item 27 is marked other than 1 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barl Smith ZADA Rodgers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 Balto. md. 21216 Harlem Ave. 20b Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Bay View Crematry 06 Donation 5 Other Specify: 22. Name and Address of Facility of Fac 21 Signature of Funeral Service Licenses ave pruto mo 2120 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line /Medical Death Narcotic intoxication and cocaine use Immediate Cause (Final disease **#**kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical AMENDED item#23a,27,28a-f,perME,g856,6/26/06 TI X UNPENDED the attending physician led for use as the burial P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the Live hirth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 V No Yes 25 Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: 1 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c, Injury at Work? 28d Describe how injury occurred Manner of Death Natural Yes 2 X No unknown Pending 5/30/2006 the unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2801 Harlem Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be Home determined (Specify) Homicide 29a Certifier 1 (Check only one)

within 24 hours after death To the Funeral Director:

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2

29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. May 31, 2006

ss of person who completed cause of death (Item 23a)

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Carried Carry

31. Date filed (Month, Day Year) State Registrar

29b. Signature

ORIGINAL

			partment of Health and Mental ertificate of Death	Hygiene 2006 1982
	్ siciar edica	VIRGINIA E. SAMPSON	Month June	2, 2006 12:30 ^{a м}
Exa Fune	mine	Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Silver Spring y) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month	4c. County of Death Montgomery of Birth h, Day, Year) 9. Birthplace (State or Foreign Country)
Direct		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Sep	t. 22,1920 Virginia
with the Ma	Directo	Maryland Prince George's Bowie	10f. Zip Code	1 ⊠ Yes 2 □ No
IOFE, INTERVICTOR Z I Z I D-UUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If filem Z 71 is marked other than natural, or terme 23a or 28a-1 show or other fraumstic event. Its Medical Englisher in the notified of	Completed by Filhers Director	4205 Enterprise Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates:	20720 E. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc., 1 ☐ Yes 2 ☒ No Specify:	U.S.A. or No- Black, White, etc. Specify: White
Z1Z1D-UU36 ad within 72 hours af giene. er then "naturel", or	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) Homemaker	16b. Kind of Business/Industry Own Home
Maryland Z nd 2 should be filed lith and Mental Hygis 27 is marked other	To Be	17. Father's Name (First, Middle, Last) Morris Forcum	18. Mother's Name (First, Mi Mabel Sn	nith
Dallinore, Mai permit. Peges 1 and 2 st Department of Health and Important: If Item 27 is no pay injury or other traum		David Sampson - Husband 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, critical complexity.	ematory or other place)	Maryland 20720 20c. Location - City or Town, State
permit. Pege Department (Important: If	once	21. Signatura Hurreral Service Adensee	22. Name and Address of Facility Gasch's 4739 Baltimore Avenue,	Hyattsville, Maryland 20
The law requires thet the death certificate be executed The law requires the talending physician and the search of the search o	eal Examiner	d		ory arrest. Approximate Interval Batween Onset and Death
at the death certifice by the attending ptrached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
requires thet been signed by should be deta	2	Part II. Other significant continuous contributing to death out not resulting in the		Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 **Unknown
ysician: The law requires to certificate has been signed director, page 2 should be e	<u>Ω</u>		1 Y	Was an autopsy findings available prior to completion of cause of death? es 2⊠No 1 □ Yes 2 □ No
tending Ph leath. tor: After th	cation:	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatie	of 28c. Injury at Work? M 1 Yes 2 No	Residence 6 □Other <i>(Specify)</i> ribe how injury occurred
Hospitet or At 4 hours after of Funeral Directibly filled in by			City or	on (Street and Number or Rural Route Number, r Town, State) the cause(s) and manner as stated.
To the H within 24 To the F complete	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
2(8)		30. Name and address of person who completed cause of death (Item 23a) (Type Yeheyis Negussie, MD) 1111 Spring St		06/02/2006 ng, Maryland 20910-4003
	State istrar	31. Date filed (Month, Day, Year) 22. Registrar's Signature		

06-03777 Taylor Sperling

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 19822

		1- For State Registrar		Certificate d	of Death		75	Reg. N		UU	0 1506
Physic Medical Exam			SPERLING				Month	2 Date of Death Month Day Year			3. Time of Death
		4a. Facility Name (if not institut			4b. City, Town	or Location		2, 2006	4c. County of		1730 hrs
		10615 Campus Way	South		Upper M		or Doding		Prince G		3
Funeral		5. Social Security Number		rs. last birthday)	If Under 1		er 24Hrs. 8 Date	of Birth(M	M/DD/YYYY	9. Birth	place (State or
Director	1	214-69-8875	1XM 2F 2	Y		Days Hours	FEB.	19	2004	Foreign Cour	WASHINGTON DC
è		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Loca	Nin-					L	
d howa	_		100. (Od Inside City Limits
ɗaryland 28a-f show any 1 <u>at once.</u>	Director	MD PRI	NCE GEORGE S UI	PPER MAR	10f. Zip Cod			10~ 0	141	- 1	1 X Yes 2 No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho atte event, the Medical Examiner must be notified at once.	Dire	10615 CAMPUS	WAY SOUTH	YAY SOUTH		20774			10g. Citizen of What U.S.A.		y?
with ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13.		as Decedent of	Hispanic Orig	gin? (Specify Yes o	or No-	14 Race - American Indian,		n Indian Black
death or ite	جّ ا	1 X Never Married 2 N	1 Armed Forces? 1 Yes 2 X No	11	Yes, specify Cul	ban, Mexican,	, Puerto Rican, etc.)	White	, etc	ir iridian, black,
s after ral",	۾ آھ		vorced If Yes, Give Year or Dates:	1_	Yes 2X				Specify:	BLA	.CK
2 hour	Completed	Elementary/Secondary (0-12)	ecify only highest grade completed College (1-4 or 5+)) 16a Decede during r	nt's Usual Occu nost of working	pation (Give I life. DO NOT	kind of work done use retired)	16b	. Kind of Bus	iness/Ind	ustry
0036 Within 7 tene. er than	nple	0	Conege (1-4 of 54)	NON				,	NONE		
5-0 led wi Hygier other		17. Father's Name (First, Middle	, Last)	1,011		1B.Mother'	s Name (First, Mide				
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	RICHARD SPERI				ST	EPHANIE M	. KII	NG		
MD 2 d 2 should lth and M in 27 is m turmatic e	ြို	19a Informant's Name/Relations HAROLD A. KINO		19b. Mailir	g Address (St	reet and Num	ber or Rural Route	Number, (City or Town	, State, Zi	p Code)
Z that a	8 9	20a. Method of Disposition		b. Place of Dispo			MITCHELL				
DOFE Iges It of H It If i		1 X Burial 2 Cremation	3 Removal from State	crematory or of	ther place)	cernetery,	Date	- 1	Location - (City or To	wn, State
		4 Donation 5 Other S	pecify: I	IARMONY			6/8/2006		ANDOVE	ER,MA	RYLAND
Balti permit. Departn Import injury			S	ľ	Name and Addre		J. B. J. ROAD LANI	ENKIN	IS FUN	ERAL	HOME 20785
Physician		23a Part I. Enter III disease, or failure. List only one cause	complications that caused the dea	nth. Do not enter t	he mode of dyin	g, such as ca	rdiac or respiratory	arrest, sh	ock, or hear		Approximate Interval
/Medical Examiner		Immediate Cause (Final disease	on each me.								Between Onset and Death
	Н	or condition resulting in death)	Due to (or as a consequence	of):						1	
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of);									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated									
uted nd ransit		events resulting in death) Last Due to (or as a consequence of):									
18760, rificate be executed ng physician and as the burial - transit	Physician/Medical	UNPENDED	AMENDED							\dashv	
18760, Tiffcate be nng physici as the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcome of pre	egnancy				23	d Date of de	elivery	
∞ ‡ ∞ s l	cian	past 12 months?	e 1 Live birth 4 Pregnant at time of 6	death		Ectopic	pregnancy		Month	Day	Year
P.O. Box 68 s that the death cert med by the attendir	ysi	1 Yes 2 No 9 Unk	nown 9 Unknown	5 Ot	her (Specify)						
P.O. s that the gned by t	by P								ite to the o	cause of death?	
S, P.C uires that n signed l							1	Yes 2	N o 3	Probably	4 Unknown
The past 12 months? A						24b Were autopsy findings available prior to completion of cause of					
Rec The licate h	ĕ	pint to condent to ? 1 ✓ Yes 2 No 1 ✓ Yes						th?	2 No		
tal cian:	performed? 1 ✓ Yes 2 No 2 No 1 ✓ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N						103	2 100			
of Vital ng Physician: After this certi	입	O 1 Yes 2 No							Other: Sce	ene	
nding ading th :: Aft	ö	1 Natural -	28a Date of Injury FOUND: POUND:	28b. Time of Ir FOUND:		ury at Work?	28d Describ Subject si		ry occurred		
Division tal or Attendir rs after death al Director: A	g 2 Accident Investigation Jun 2, 2006 1718 hrs							id Number or Rural Route Number, City			
Div italor	E E	3 Suicide 6 Could 4 Homicide determ			r, ractory, billice	building, etc.	or lown	. State)			
Hosp 24 hor Fune rtely fi		20+ C++if	Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manage as stand						er Marlboro, M		
To the Howithin 24 F	장니	2 Wiedical Exam	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started and manner stated							se(s)	
	ž	29b. Signature and title of certifier							(Month, E	Pay, Year)	
. ~			NI. /E		O.C.	M.E.		June	3, 2006		
(1/1/2)			who completed cause of death (Iter								
Sta	oto	Jack Titus MD. Dept	uty Chief Medical Examine 2. Registrar's Signat		n Street, Ba	itimore, Mi	D 21201				
Registi		JUN 0 7 201		brede							

			For State of Maryland / Dep State Registrar Ce	artment of Health and ertificate of Death	Mental Hygier	4000 10040					
7	Physicia		1. Decedent's Name (First, Middle, Last) Betty F. Strine		2. Date of Death Month June 4.	3. Time of Death 2006 1458 M					
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospit	4c. County of Death Montgomery							
48	Funeral Director		5. Social Security Number 214-34-1088 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday 86 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Yea	9. Birthplace (State or Foreign Country) 1919 – Wales					
Maryland 2121	show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Md. Montgomery R	ocation Cockville		10d. Inside City Limits 1 Yas 2 □ No					
	with the N la or 28a-f	Director	10e. Street and Number 9701 – Veirs Dr.	10g. (Citizen of What Country?						
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Examinat must be natilised at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 11. Was Decedent Ever in U.S. Armed Forces? 11. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 11. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces. 14. Was Decedent Ever in U.S. Armed Forces. 15. Was Decedent Ever in U.S. Armed Forces. 16. Was Decedent Ever in U.S. Armed Forces. 17. Was Decedent Ever in U.S. Armed Forces. 18. Was Decedent Ever in U.S. Armed Forces. 19. Was Decedent Ever in U.S. Armed Forces. 19. Was Decedent Ever in U.S. Armed Forces. 19. Was Decedent Ever in U.S. Armed Forces. 19. Was Decedent Ever in U.S. Armed Forces. 19. Was Decedent Ever in U.S. Armed Forces. 19. Was Decedent Ever in U.S. Armed Forces. 19. Was Decedent Ever in U.S. Armed Forces. 19. Was Decedent Ever in U.S. Armed Forces. 19. Wa	Was Decedent of Hispanic Origin? (street Yes, specify Cuban, Mexican, Puei	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
	I within 72 hou liene. r than "nature in wad rail	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) COOf Reader	orking	Kind of Business/Industry					
	uld be filed fental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last) William John Pearn		me (First, Middle, Maide el Annie 1	en Sumame)					
	1 and 2 shou Health and N em 27 is ma					Al Route Number, City or Town, State, Zip Code) ROCkville, Md. 20850					
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or oth		20a. Method of Disposition 1X Buriai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens-6/10/06-Frederick, Md.								
Balt	sh.,DC										
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one rause on each line. Immediate Cause (Final disease or condition resulting in death) a	Le on t For Latery Pese	Luze	Approximate Interval Between Onset and Death					
I Records, P.O. Box 6	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
	death certii e attending d for use a	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year					
	signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 Tunknown						
		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
ſVit	Physician: This certifice ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 € R/Outpatie	Hospital: Other							
vision	sing After fune	ation; T	27. Manner of Peath Natural 5 Pending 2 Accident 1 Pending 28a. Date of Injury 28b. Time	of 28c. Injury at Work? M 1 Yes 2 No							
	tai or Atters after de ai Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attenc within 24 hours after deatt To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
)	To With	Σ	29b. Signature and title of certifier Cooling 10	29c. License number 033 76	290.0	oate signed (Month, Day, Year) NO 6					
1-	(2)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.William Dooley - Shady Grove Adventist Hospital, Rockville, Md.								
1	Sta Registi		JUN 0 7 2006	W							

		. For	State of Marylan	d / Departm	ent of Health ar	nd Meni	tal Hygien	eanna	10021	
		1 - Stete Registrer		Certific	ate of Death		Reg. N	lo. 4000	13024	
Physic /Medi		1. Decedent's Name (First, Middle, Last) MAR GAR	ET 0	EAN	SNOW		0 =	ay Year	3. Time of Death	
Exami		4a. Facility Name (If not institution, give s	treet and number)	4b. (City, Town, or Location of [Death	4	c. County of Death		
		Washington Adventi 5. Social Security Number 6. Sex			Takoma Park	Hrs. 8 D	ate of Birth	Montgome		
Funeral Director		220-48-9609	M 2図F 81	Yrs. Mon		Min. (/	Month, Day, Yea n. 16, 19		place (State or Foreign ntry) ouri	
ehow		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location					10d. Inside City Limits	
Mary Fied	io	Maryland Prince G	eorge's	Capitol H	leights			,	1 ☐ Yes 2 ☑ No	
or 28	Director	10e. Street and Number		100	. Zip Code		10g. C	Citizen of What Cou	ntry?	
eath v	Funerai	1911 Brooks Drive	#204 12. Was Decedent Ever in U.	S. 13. Was D	20743 ecedent of Hispanic Origin	n? (Specify \	Yes or No-	USA 14. Race - Ameri	can Indian,	
after of	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		ecedent of Hispanic Origin specify Cuban, Mexican, F as 25 No Specify:	Puerto Ricar	n, etc.)	Black, White,	etc.	
be filed within 72 hours after death with the Maryland lat hygiene. Id hygiene. Id other then "natural", or iteme 23e or 28e-1 show event, the Medical Expiration must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:				100	Specify: Whi		
in 72 I	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give kind o	Usual Occupation of work done during most of OT use retired)	f working	166.	Kind of Business/In	dustry	
d with giene.	mo.	Elementary/Secondary (0-12)	Cottege (1-4or 5+)	Teacher			E	ducation		
be file tal Hy od oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's	Name (Firs	st, Middle, Maide	an Sumame)		
in Lilinoie, Mad yield Z. I.Z. 1370030 nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar adminent of Health and Mental Hygiene. ortant: If item 27 is marked other then "natural", or Iteme 23e or 28e-1 ehov injury or other traumatic event. The Medical Experimental be notified at	2	Ernest E. Welborn 19a. Informant's Name/Relationship (Ty)		19b. Mailing Add	Mary Iress (Street and Number of		liller ute Number, City	or Town, State, Zig	o Code)	
ING 2 salth ar 27 is pr trau		Sharie McCluney			ooks Drive #2					
of He as 1 gr		20a. Method of Disposition 15 Burial 2 Cremation 3 R	20b. P	lace of Disposition emetery, crematory t Lincoli	(Name of	Date		Location - City or To		
permit. Pages Department of Important: If if eny injury or once.	'	4 □Donation 5 □ Other (Specify)		Ce	metery Ju	ne 8,2	2006 Bre	ntwood, Ma	ryland	
permit. Departimont import		21, Signature of Funeral Service License	Jacob .	Franc	e and Address of Facility Lis J. Collin Iniversity B	ns Fur	eral Ho	me, Inc.	MD 20001	
		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death					r shrring	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	Atherosclero	tic Card	iovascular D	isease			Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as a consequ							
*	Je L	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	uence of):						
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e be executed rsician and burial-transit	cai Ex									
DO /										
th certi	M/W	230. was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Fetel		pic pregnancy			23d. Date of deliv	•	
The COLOS, F.O. BOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	4☐Pregnant at time of do 9☐ Unknown		r (specify)			Month	Day Year	
s that	by Pr	Part II. Other significant conditions con	tributing to death but not res	ulting in the underly	ing cause given in Part I.	1	23e. Did tobacco	use contribute to t	he cause of death?	
w requires been sign should be			1 Tyes					2 No 3 Probably 4 Munknown		
N S S C	Completed					_	24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of	
VICAL DEC Sicien: The law s certificate has t lirector, page 2 s	0	25. Was case referred to medical			26 Place of		□ Yes 2		2 No	
ng Phy Ifter this	To B	examiner? 1.20/es 2 No Hospital: 1 Inpatient 2.50 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resid								
Attending at death. Sector: After by the fune	ficat	3 Suicide 6 Could not be determined 6 See. Place of Injury - At home, farm, street, factory, office 28f. Location (Street)					ocation (Street a	t and Number or Rural Route Number,		
tal or safter al Dire	Certification:	4 Homicide	building, etc. (Specify)			City or Town, State)				
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medicai	29a. Certifier (Check only one) (Check only on								
To the within To the	₹ S	29b. Signature and title of certifier	1		29c. License number		29d. D	ate signed (Month,	Day, Year)	
2		100	(mg		603,	19	, (26 01	2006	
		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	MAN	7	600 C	ARRA	AVE	
S	tate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture d				7" [1 1 1	1-1, 1110	
Regis	trar	JUN 8 201	Jo Maries A	A PASSAGE						

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 6:00 P.M ,0006 Thelma Mae Smith une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Yrs. 214-09-9992 94 Director April 28 1912 Maryland Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County worle permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23s or 28s-1 ehow pri julyry or other treumatic event, the Modical Examinar must be rediffed at once. X☐ Yes 2☐ No Maryland Washington Hagerstown Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 333 Mill Street 21740 U.S.A by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ZY No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No White Specify: Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Gertrude Wyant Snodderly Ernest Snodderly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald G. Smith 13107 Woodburn Drive Hagerstown Maryland 21742 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) Harbaugh's Cemetery Rouzerville Pennsylvania 6-12-06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tature. List only one cause on each line. <u> 1331 Eastern Blvd. N. Hagerstown Maryland 21742</u> Immediate Cause (Final disease or condition resulting in death) Renat **Physician** CU /Medical Due to (or as a consequence of): **Examiner** ve mi perna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit rosepsis Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Triknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has b irector, pege 2 s autopsy performed? 1 ☐ Yes 2 NO the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 hpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 | Yes 2 | ₩6 2 ER/Outpatient 3□ DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Tes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 06 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) opal 1126 MURSHED 21740 Hogersling W D FARID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Wayne Willard Stallings ### A Posity Name (Tox residency, pass used and combon) ### A Posity Name (Tox res			1- For State Registrar AMEND #26 P		iryland {Dep /06 CCH © e	artmen rtificat	t of H e of L	ealth a Death	ind M			e2 ()	06	1982
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The state of the s	Funeral	161	8113 Woodland Lar 5. Social Security Number 6. Se	ne 7. Age		Che If Under	sape 1 Year	ake B	each	8 Date of B	lirth	Ca]	vert	place (State or Fore
Elementary/Secondary (0-12) College (1-4cf 5+) Police Officer Police Dept.	ס	or.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					Feb.	19,	1936	mary	Od. Inside City Lim
Elementary/Secondary (0-12) College (1-4cf 5+) Police Officer Police Dept.	with the N 3a or 28a-f	i Direct	10e. Street and Number		Une	10f. Zip	Code	each			10g. C	J. Citizen of What Country?		
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Description of the property of	100	Completed	(Specify only highest grad Elementary/Secondary (0-12) 12	ie completed)	(Give	kind of wor DO NOT us	k done d e retired,	uring most	of workii	ng	Was	hing	ton I	OC Metro
Marie Stallings - Wife 200 Algorithm of Deposition (Special Processing of Deposition Computer (Special Processi	should be fill and Mental Hy s marked oth umatic even	Be	Blair Beal Stallin		19b. Mailir	ng Address	(Street a	Н	elen	Virgi	nia	Alve	y	Code)
21. Signature of Funch Service Lethies M00053 April Enter the clienter, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest. Approximate on the control of	es 1 and of Health if Itam 27 or other tr		20a. Method of Disposition 1 \(\Delta \) Buria \(\Delta \) Cremation 3 \(\Delta \)	Removal from State	cemetery, crer	natory or ot	ie of her place)	D	ate	20c. l	ocation - (City or To	wn, State
Physician (Medical Example) Sequentially list conditions, if any isosuring in death) Sequentially list conditions, if any isosuring in death) Sequentially list conditions, if any isosuring in death) Sequentially list conditions, if any isosuring in death isosuring in death) Sequentially list conditions, if any isosuring in death isosuring in death) Sequentially list conditions, if any isosuring in death	permit. P Departme Importan any injur		21. Signature of June 11 Sewige Lea	9 M0005	53 22 / Hi	. Name and untt	a Address	s of Facility	ome	3035 P0B	01d 156,	Wash	ningt	on Rd.
The second of th	/Medical	3 7/	Immediate Cause (Final disease or condition	ications that caused to the cause on each line a	PIRA Norconsequence of):	er the mode	of dying	, such as ca		r respiratory a	arrest,			Approximate Interval Between Onset and Death
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d		ai Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C/rr	hosis				•					
25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 28 Injury at Work? 1 Yes 2 No 28 Date of Injury 28 Injury at Work? 27. Manner of Death 28 Date of Injury 28 Date of	the death certificate y the attending phy ched for use as the	ysician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at ti	Fetal death 3									,
25. Was case referred to medical examiner? Type 2 No	equires that hen signed b ould be deta	ρ			not resulting in the ur	iderlying ca	use giver	in Part I.	_				•	
27. Manper of Death 1 1 1 1 1 1 1 1 1 1			25 Was and related to market						_	auto perfo 1 Yes	psy prmed2 No	pri de	or to com	pletion of cause o
N. Merdono MD 20060638 6/9/06.	nding Physicis th. : After this cert s funeral direct	To B	examiner? 1 Yes 2 No Part No P	1 Inpatient		28	C. Injury	4 □ Nursi	ing Hom	e 5 X Resi	dence			1
N. Merdono MD 20060638 6/9/06.	oral or Arrer urs after dea oral Director illed in by the													
N. Merdons MD 20060638 6/9/06.	thin 24 ho the Fund ompletely t	Medica	one)	ier. On the pasts of e	xamination and/or inv	estigation, i	n my opii	nion, death	occurred	d at the time,	date and	d place, an	d due to	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	≥ ¥ 5 8		N. Mero						638	?	290. Da			

SAMPSON, Purnell

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	lealth and Mental Hygiene

			1 - For State Registrar	State of Maryland		artment of t tificate of			giene 200	6 19827
	Physic		1. Decedent's Name (First, Middle, Last) Purnell Sampson					2. Date of Dea Month	Day . Yes	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give stre		CSDital	4b. City, Town,	or Location of Death	June	4c. County of D	~
	Funeral Director		5. Social Security Number 6. Sex 213-24-4423	7. Age (In yrs. la	a <i>st birthday)</i> 77 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day July 26	year) 9. 1 5,1928 Ma	Birthplace (State or Foreign Country) aryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f show Linust te natified at	ţō	MD Dorches	1	,	Hurloc	k			1 ☐ Yes 2 ☑ No
	ith the	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	Country?
	s 23e	rai	4214 E.N. MktH				1643		United S	tates
920	72 hours after death with the Marylan "naturel", or Items 23e or 28a-f show office! Examirer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U.S Armed Forces? 1 \(\text{Yes} \) 2\(\text{No} \) No If Yes, Give Year or Dates:	11	Vas Decedent of I Yes, specify Cub ☐ Yes 2 ∰No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. Black
5-0	72 ho	eted	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	16a. Deced	ent's Usual Occup	pation during most of work d)	ina	16b. Kind of Busine	ss/Industry
21215-0036	e filed within al Hygiene. f other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			use Work		Food Pro	cessing
br	e filed al Hygi other vent,	Be C	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
ylaı	2 should be to and Mental is marked of raumatic ever	To	John L. Sampson					Jones		
e, Maryland	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "natuu any injury or other traumatic event, It a Mudical ance.	33	19a. Informant's Name/Relationship (Type, Martha Sampson/S	Spouse	4214	E. N.	MktHu	ırlock	Rd., Hur	10ck, MD
Baltimore,	ages 1 nt of H t: If ite / or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem		netery, crem	ition (Name of atory or other pla	ce)	Date	20c. Location - City	or Town, State
altin	artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify)21. Signature of Funeral Service Licenses.	1 nor		own Cem.	ess of Facility	17700	ast New M	arket, MD
B	permit. Departr Imports any inji		Muhail 7. E	skin	21	6 N. Mai	n St Fe	mptom Fu	neral Hon rg, MD 21	ne, P.A.
	Physician /Medical	y	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one disease or condition resulting in death)	ions that caused the death. cause on each line.	Do not ente	r the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	rificate be executed by physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque		Henry	Disen	K C		15×2
	rtificat ng phy as th		IE EEMALE.							
.O. Box	The law requires that the death certile has been signed by the attendin rage 2 should be detached for use	Physician/N	in the past 12 months?	If yes, outcome of pregnand 1 Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3□E	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year
٥	res that igned by be deta	by Pr	Part II. Other significant conditions contrib	uting to death but not result	ing in the und	terlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ords	w require been sig should b							1 □ Ye	s 25 No 3 1	Probably 4 Unknown
Il Records,		Completed						24a. Was an autopsy perform	prior to ned? death?	
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	oital:		Oth	26. Place of Death			
of		n: To	27. Manner of Death	1 Inpatient 2	B/Outpatient 8b. Time of	3 DOA Oth	at 2	me 5 Resider 28d. Describe ho	nce 6 Other (Sp w injury occurred	ecify)
ion	andin ath. or: Afi	atlo	2 Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No			
Division	el or Attend s after death al Director: ,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	et, factory, office	3	28f. Location (Str. City or Town,	eet and Number or F , State)	Rural Route Number,
	To the Hospitel or Atta within 24 hours after de To the Funerel Directa completely filled in by the	edical (29a. Certifier (Check only one) Check only one) Certifying Physicial Examiner:	n: To the best of my knowledge. On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the tin stigation, in my o	ne, date and place, a pinion, death occurre	and due to the car ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	within To t		29b. Signature and title of certifier	0 1		29c. License		29	d. Date signed (Mon	th, Day, Year)
			30. Name a ladd ss of person who complete the state of th	u m	0-1/5	102	6388	1	une 13,	2006
			30. Name a ladd ss of person who complete with the state of F	eted cause of death (Item 2 William Ma	3a) (Type, Pi	int) 2 Calli	ong the	rlock V	nd 210	643
	Sta	è	31. Date filed (Month, Day, Year)	32. Regisfrar's Signatur			- //	, , ,		

Registrar

DILLMAN FRANCISCO SEBASTIAN ORUZCO
06-03917 Please Type or Print in Black Indelible Ink
Unk Unk
State of Maryland / Department of Health and Mental Hygiene

TIK OTIK		1- For State Registrar	Cert	tificate of		ia wentan		eg No 20	05 1982		
Physicia ledical Examir	n/	1. Decedent's Name (First, Middle, Last) Dillman Francisco	Sebastian-(Orozco			2. Date of Dear Month June 8, 20	Day Year	3. Time of Death 0257 hrs		
and the same of th		4a. Facility Name (if not institution, give s				r Location of Deat		4c. County of Dea			
Funeral	4	Rt. 480 near Greensboro 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	Greensbor		s. 8. Date of Bir	Caroline th(MM/DD/YYYY) 9. E	ırthplace (State or		
Director		N/A Usual Residence of Decedent	2 F 20	Yrs.	Months Da	ys Hours Mir		Fore	^{ign} Guatemala		
au s	ı	10a State 10b. County		Town or Locatio				 	10d. Inside City Limits		
Maryland 28a-f show : d at once,	ē	MD Caroline	Gre	eensbor			· · ·		1 X Yes 2 No		
th the Mary 23a or 28a notified at	I Director	10e. Street and Number 121 N. Main Street			10f Zip Code 2163	9	11	Og Citizen of What Co Guatemala	untry?		
more, MD 21215-0036 Pages I and 2 should be filted within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces? Yes 2 No	If Ye	s, specify Cuba	ispanic Origin? (S in, Mexican, Puerto	Rican, etc.)	White, etc.	rican Indian, Black,		
ours after atural", xaminer	2	3 Widowed 4 Divorced If of 15. Decedent's Education (Specify only	Dates:	16a. Decedent	s Usual Occupa	ation (Give kind of e. DO NOT use ret	work done	Specify 16b. Kind of Business	Hispanic JIndustry		
5-0036 led within 72 hours af Hygiene, other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) unknown	Collage (1-4 or 5+)		scaper	e. DO NOT use rel	ired)	landscap	oing		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Francisco Sebastia	an					Maiden Surname) Drozco Cint	20		
D 21 Should bend Mer		19a Informant's Name/Relationship (Type						nber, City or Town, Star Marydel, MI			
and 2 sho and 2 sho Health and item 27 is traumati		Victor Hugo Cifuent 20a. Method of Disposition	20b. PI	lace of Disposit	ion (Name of ce		Date Date	20c. Location - City of			
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Ceme		de San	Isidro U			,Guatemala		
Balt permit Depart Import injury		21. Signature of Funeral Service Licenses	200			s of Eacility Id Helfen I: Greens		neral Home,	, PA		
Physician /Medical		23a Part I Enter the disease, or complicate failure. List only one cause on each	line.	Do not enter the	e mode of dying	, such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and		
Examiner	İ		ead and Leg Injuries to (or as a consequence of)	r:					Death		
	e.	Sequentially list conditions, if any, leading to immediate	e to (or as a consequence of)	<u> </u>							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of)								
and and		d						<u>,</u>			
o,	Medical		MENDED 23c. If yes, outcome of pregna	ancy				23d. Date of delive			
	sician/N	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of dea	2 Feta	al death 3	Ectopic pregn	ancy	Month Month	Day Year		
Box e death c the atten	Physic	1 Yes 2 No 9 Unknown	9 Unknown	5 Othe	er (Specify)			**			
P.O.	含	Part II. Other significant conditions of	ntributing to death but not res	sulting in the un	iderlying cause	given in Part I.		bacco use contribute to			
of Vital Records, ag Physician: The law requirement. The the requirements that this certificate has been someral director, page 2 should be	ompleted						24a Was a autop	sy prior to	utopsy findings available completion of cause of		
tal Rec	O										
Vital hysician this cert	e Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital: 1 Inpatient 2 E	ER/Outpatient	emanus.	·Othor: -		Residence 6 🗸 Othe	er: Scene		
on of 'nding Ph	ion: T	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	28b Time of Inj 0225 hrs		ury at Work? Yes 2 ✔ No		now injury occurred of car in collision			
Division rate of a rate of	Certification:	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At hor				28f. Location (S or Town, Si		ural Route Number, City		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:			(Specify) Major Road To the best of my knowledge	e, death occurre			due to the caus				
To the Ho within 24 F To the Fu	Medical	one) 2 Medical Examiner: One 29b. Signature and title of certifier	n the basis of examination and dimanner stated.	d/or investigatio	on, in my opinio 29c. Licen		at the time, date a				
	5	Queste				.M.E.		June 8, 2006	onui, Day, real)		
		30. Name and address of person who con			root Douis	oro MD 0400	1	l			
	ate		Medical Examiner 1 32. Registrar's Signature		reet, Baltim	ore, MD 2120	1				
Regist		JUN 1 2 2006	- 107	& long	1 1 3						

ORIGINAL

			For State Registrar	State of Marylan	d / Department of Certificate		ental Hygie	4000	19829
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Las Norman 4ay Facility Name (If not institution, give Uninsula Regiona	street and number)	1 ing 4b. City, Tov	wm, or Location of Death	2. Date of Death	Day Year	3. Time of Death 2024 M
P-1939	Funeral Director		5. Social Security Number / 6. So	9X 7. Age (In yrs. I	Yrs. Months D		8. Date of Birth (Month, Day, Ye	9. Birthpli Count	ace (State or Foreign ry) rylund
an Stanfing 220-2	I 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. I le marked other then "natural", or Items 23a or 28a-f ehow reumatic event, the Medical Examinar must be notified at	To Be Completed by Funeral Director	Maryland Somers 10e. Street and Number 3545 Freedow 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grave) Elementary/Secondary (0-12) 12 th grade 17. Father's Name (First, Middle, Last) Levoy Will 19a. Informant's N me/Relationship (7)	12. Was Decedent Ever in U. Armed Forces? 1 Yes, Give Year or Dates: ucation de completed) College (1-4or 5+)	S. 13. Was Decedent If Yes, specify 1 Yes, specify 1 Yes 200 16a. Decedent's Usual Or (Give kind of work diffe. DO NOT use re	coupation one during most of working 18. Mother's Name Clara 18. Mother's Name Clara reet and Number or Rura	ng Sel	Citizen of What Count U.S. A. 14. Race - America Black, White, e Specify: Black Kind of Business/Indu F Employed (en Sumame)	in Indian, itc. ack ustry owner Joperata
	permit. Pages 1 and Department of Health Important: if Item 27 eny injury or other t once.		Patricia A, Ban 20a. Method of Disposition 1 Burial 2 Deremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licenses	Removal from State 20b. Place Sall	ace of Disposition (Name of ametery, crematory or other 25 Name and Ac 3 6639	actory lela ddress of Facility / Lampden	17/06 17/06 Anthony E	adelphia Location-City or Town Salisbury Ward Fly In Cass Ann	med, Home
760,	Physician /Medical Examiner prize pr	ical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or as a consequ	liac ar, ence of): r Mary Ar ence of):	the Linux	r respiratory arrest,	1	Approximate niterval Between Onset and Death 20 mixs
P.O. Box 68	ath certific ittending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic pregna			23d. Date of delivery Month D	, lay Year
	w requires that the de been signed by the s should be detached f	þ	Part II. Dther significant conditions co	ntributing to death but not result	Iting in the underlying cause	given in Part I.		ouse contribute to the	1
tal Reco		e Completed	25. Was case referred to medical	Periphor at	Masslew	Diseas	24a. Was an autopsy performed?	death?	y findings available pletion of cause of
₹	Physician: this certifice ral director, p	ToBe	examiner?	Hospital: 1 Impatient 2 E	R/Outpatient 3 DOA	26. Place of Death Other: 4 □ Nursing Hom		6 ☐Other (Specify)	
Division of Vital Records,	De fe	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hon building, etc. (Specify)	M 1	njury at 2 Work? I □ Yes 2 □ No	8d. Describe how inj	ury occurred	Route Number,
		edicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	29c. Lice	ense number	d at the time, date as	nd place, and due to the	ne cause(s)
	Stat Registra	e	30. Name and address of person who come address of person who come and address of person who come address of	ompleted cause of death (Item: CHAW 39 32. Registrar Signatu	23a) (Type, Print) Cowld Digital Control of the Co	-2005 c	Sub 301	6/11/0. Soldy 3.1.	6 4122829

			1 - For State Registrar	State	of Marylar		artmen rtificat			and M	_	giene 2	006	19830
	Physici	an	Decedent's Name (First, Middle Time 1								2. Date of De Month	Day	Yeer O6	3. Time of Death
	/Medio		Linda Sue 4a. Facility Name (If not institution				4b. City,	Town, or	Location of	of Death	_06		inty of Death	14.00
	Lxaiiiii		WMHS- Bradd	ock Cam	209		(Com	berlo	ind		A	llegan	4
	Funeral		5. Sociaf Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bird (Month, Da	th ly, Year)	9. Birth	place (State or Foreign
	Director		233-96-9540 Usuaf Residence of Decedent		50	Yrs.					June 5	, 1956		ral Co., WV
arvla	o a	7	10a. State 10b. County		100. 01	,								10d. Inside City Limits 1 Yes 2 No
d 21215-0036 · ·	rel', or iteme 23a or 28e-f show Examinat must be notified at	Director	WV Min	eral		<u>Ke</u>	yser 10f. Zip	Code				10g. Citizen	of What Cou	
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deeth	8 S	Funeral	11. Marital Status	12. Was De	edent Ever in U	I.S. 13.	Was Dece			gin? (Sp	ecify Yes or No Rican, etc.)	- 14. F	Race - Ameri	
efter 6	ar a		1 Never Married 2 Mar	ned Armed F	2 📉 No		ir res, spe 1 □ Yes		n, mexican Specify:	i, Puerto	Hican, etc.)		3fack, White,	etc.
5-0036	4	d by	3 XWidowed 4 □ Divorced	Year or	Dates:									White
<u>5</u>	'naturel',	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	16a. Dece (Give	dent's Usu	al Occupa	ation during mosi f)	t of work	ing	16b. Kind o	f Business/In	dustry
2121 d within	then en	m du	Elementary/Secondary (0-12)	Coflege	(1-4or 5+)				″ Servi			Pota	1 Don	t. Store
ם ק		Be C	17. Father's Name (First, Middle,	Last)			04310	IIIC I			e (First, Middle,			L. SLOTE
<u>a</u>		ToB	Alvie H. Sw	ick, Jr.					Lo	is V	. Thorr	16		
Maryland			19a. Informant's Name/Relations	hip (Type, Print)		19b. Maifi	ng Address	(Street	and Numbe	or Rura	al Route Numbe	er, City or To	wn, State, Zip	Code)
	n 27		Mr. & Mrs. Alv	ie Swick/			Secon		reet		ser, WV			
altimore,	0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removat from		Place of Dispo cemetery, crea	nsition (Name matory or c	ne of other plac	(e)	June	19	20c. Locatio	on - City or To	own, State
tim	tant:		4 Donation 5 Other (S		Bi	ser Ce			1		06	Keyse	er, WV	
Bal	Department Important: If eny injury or once.		21. Signature of Funeral Service	Licensee	IIL	> 2			ss of Facilit	S	mith Fu			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	th. Do not en					Keys		26	5726 Approximate fnterval Between
8760, was as a paracuted with	hysician bhysician Medical xaminer tiansit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a consequence of the cons	quence of):	rgs Tul	land on	en a wid	re h	ush reco	hyp Sto	okla sls	2 Exect
O. Box 6	been signed by the ettending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live	utcome of pregna birth 2 Peta nant at time of d	al death 3	⊒Ectopic pi ⊒ Other (sc						Date of delive	ery Day Year
ds, P	signed to	þ	Part II. Other significant condition	ons contributing to	death but not res	sufting in the u	nderlying o	ause give	en in Part I.		23e. Did to			he cause of death?
Records,	s bee 2 shou	Completed		er haei	all						24a. Was		b. Were auto	psy findings available mpletion of cause of
ř	ete he	E			8						perto	rmed? 2DNo	death?	2 No
/ita	ertific actor,	Be (25. Was case referred to medica examiner?							of Death	(Check only o	nne)		
	this c	2	1 ☐ Yes 2 Z No		· · · · · · · · · · · · · · · · · · ·	ER/Outpatier			4 LINU		me 5 Resid			y)
vision of Vita	th. After funer	tion	27. Manner of Death 1 Natural 5 □ Pendir 2 □ Accident investi	9	of Injury oth, Day Year)	28b. Time o fniury	f M	8c. Injury Work 1 □ '	/at <br Yes 2 □!		28d. Describe h	now injury occ	curred	
= 5	after dea Director d in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 200. Plac	e of fnjury - At hi ding, etc. (Specif	ome, farm, sti fy)	reet, factor	y, office			28f. Location (S City or Tox	Street and Nu vn, State)	mber or Rura	al Route Number,
To the Hospital	within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the and ma	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date and pinion, deat	d place, th occurr	and due to the e	cause(s) and date and plac	manner as si e, and due to	tated. the cause(s)
, and	within To the	ž	29b. Signature and title of certifie	110			290	. License	number	0		29d. Date sig	ned (Month	Day, Year)
)	M		yotan	Melle	Zeur	0)1	£D.	<u> ソー</u>	17	5 2	6	fun.	1500	,2006
•	, /		30. Name and address of person	Who completed car	ise of death (fter	11 23a) (Type,	Sofa	N/ [Rive	, (lumbe	plan.	/ m	215/12
	Sta	ate	31. Date filed (Month, Day, Year)	2 2006 32.	legistrar's Signa	atuk	reals		NIVE	- 1	UITOE	MUI)	1 1110	aljua
	Regist	rar	JUNA	N 4000		1								

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cor	10d. Inside City Limits ***X*es 2 \(\) No n of What Country? S.A. Race-American Indian, Black, White, etc. Pecify: Black of Business/Industry t Thrift Store f Laurel mame) mas own, State, Zip Code) 2 0 7 2 3
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Cor	9. Birthplace (State or Foreign Country) 9.4.4 Maryland 10d. Inside City Limits 12 Xes 2 No n of What Country? 1.S.A. Race - American Indian, Black, White, etc. Pecify: Black of Business/Industry t Thrift Store f Laurel mane) mas pwn, State, Zip Code) 2.0.723
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To Eight of the state of the st	mane) Mas own, State, Zip Code)
	DIM LOWING
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, cremation) or other place) 4 Donation 5 Other (Specify) MD National Mem 6/10/06 Lau 20c. Location of Fundamental Service Licensee	ion - City or Town, State
Physician /Medical Examiner Physician /Medical Examiner Physician /Medical Examiner Physician /Medical Examiner Physician /Medical Examiner Physician /Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	• 20850 KVIII e Md Approximate Interval Between Onset and Death W. e
The state of the past 12 months? 1	Date ol delivery Month Day Year
7 23e. Did tobacco use of the underlying cause given in Part I.	contribute to the cause of death?
	4b. Were autopsy lindings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury oci (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	Other (Specify) curred imber or Rural Route Number,
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signature and title of certifier 29d. Date signature and title of certifier	ce, and due to the cause(s) gned (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PR, TAM S SAINI 9101 Cherry Lene Suite LII LAUREL MD State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	20708

06-03837 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Richard Tull 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0255 hrs Medical Examiner June 5, 2006 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Wicomico Peninsula Regional Medical Center Salisbury 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Foreign Months Days Hours Director Country) 1 × M 2 5 10d Inside City Limits 10c. City, Town or Location 10b County 10a State 1 X Yes 2 No SALISBUR 28a-f show items 23a or 28a-f shovust be notified at once. 17) Director 0. Zip Code 10g. Citizen of What Country? 10e. Street and Number II SA 2180 4. Race - American Indian, Black Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in Funeral Armed Forces? rmit. Pages I and 2 should be filed within 72 hours after death a opartment of Health and Mental Hyggene. pportant: If item 27 is marked other than "natural", or item jury or other traumatic event, the Medical Examiner must b. Never Married 1 Yes 2 No Specify: BLACK Yes 2 No specify Divorced <u>م</u> 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Flementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 ABORER DOSTRUCTION 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ATERS Be ME City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number MD 21841 EWARK MOTHE 20b. Place of Disposition (Name of cemetery, Date 20c. Location crematory or other place) 2 Cremation 3 1 Burial Removal from State EMETERY Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licensee 2/801 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or held Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Gunshot Wound of Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED ysician a To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burna Division of Vital Records, P.O. Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Nursing Home 5 Inpatient 2 🗸 ER/Outpatient 3 DOA Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month Day Year) Jun 5, 2006 28c. Injury at Work 28d. Describe how injury occurred 28b. Time of Injury Manner of Death Certification: Subject shot 0005 hrs Natural 1 Yes 2 V No 5 Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be 3 Suicide or Town State Catherine Street, Salisbury, MD determined (Specify) Lodge a V. Homek 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe June 5, 2006 O.C.M.E

NX

Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. 31. Date filed (Month, Play, Year) State Registra

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 egistrar's Signature IN THE MENT

2006

		•	For State Registrar	State of Ma	-	epartment of F Certificate of			ene2 () () (5	19833
Ph	ysicia	_	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
/1	Nedic	al -	ETHELINE UNI 4a. Facility Name (If not institution, give	ERDUE street and number)		4b. City, Town, o	r Location of Death	JUNE 2	4c. County of Deat	8:45 A M
) Ex	amin	er	FOREST HAVEN NURS			CATONS			HOWARD	
Fun Dire			5. Social Security Number 6. S 217-76-3633 1	ex 7. Ag □ M 2∏ F 66	e (In yrs. last birtho Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JULY 29	Year) 9. Birt Co 1939 NOR'	hplace (State or Foreign untry) TH CAROLINA
yland	ㅋ		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
e Mar	peilli	ctor	MD PRINCE (GEORGE'S	BOWIE	ħ				1X Yes 2 ☐ No
with th	De no	Director	10e. Street and Number			10f. Zip Code 2071	5	10	g. Citizen of What Co U.S.A.	untry?
leeth v	DAME	Funeral	3111 TINDER PLAC	12. Was Decedent	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba		cify Yes or No-	14. Race - Ame	rican Indian,
5-UU36 72 hours after deeth with the Maryland natural; or iteme 23a or 28a-f ehow	Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 💆! If Yes, Give Year or Dates:	No	If Yes, specify Cuba		Rican, etc.)	Black, White	e, etc. LACK
15-003 72 hours "natural",	dical	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. D	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	pation during most of worki	ng 1	6b. Kind of Business/	Industry
Maryland 21215-0035 d 2 should be filed within 72 hours af th and Mental Hygiene. ?? Ie marked other then "naturali", or	e Mes	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	fe. <i>DO NOT u</i> se retired ISABLED	d)		NONE	
filed within I Hygiene.	ant, th	ပိ	9th 17. Father's Name (First, Middle, Last)		D	TORDIED	18. Mother's Name	(First, Middle, M		
land be dental	tic ev	To Be	JIM UNDERDUE				CARRIE	JAMES		
2 should and Men	or other traumatic		19a. Informant's Name/Relationship (**		lailing Address (Street				
	her tra		MARY WRIGHT/SIST	ER		SANDALWOO				
Baltimore, bernit. Pages 1 ar Department of Hea mportant; If item	ury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specified)			isposition (Name of crematory or other plac VET CEMETEI	RY = 6/9/2	-	Oc. Location - City or WASHINGTO	
Baltimo permit. Page Department Important; If	any in		21. Signature of Funeral Society	see √		22. Name and Addre	REMITE THE		INS FUNERA K, MARYLAN	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do no	enter the mode of dyir	ng, such as cardiac c	r respiratory arres	st,	Approximate Interval Between Onset and Death
Physic			Immediate Cause (Final disease or condition resulting in death)	a CEREB	and the second second	COMBOSIS				Chiset and Death
/Med Exam			1	Due to (or as	a consequence of)					
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cuted	transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C						
68760, filicate be executed physicien and	the burial-transit		resulting in death) Last	Due to (or as	a consequence of)					
.	as the	edicai		0						
9 a a	tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify) _	у		23d. Date of del Month	very Day Year
thet the	be detac	by Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting in t	ne underlying cause giv	ren in Part I.	23e. Did toba	acco use contribute lo	the cause of death?
rds quire: en sign	should be							1 □ Yes	s 2□No 3□Pr	obably 4 Unknown
Division of Vital Records, to Attending Physician: The law requires tatler death. Director: After this certificate has been signe	9 2	Completed						24a. Whas an autopsy perform	prior to r	topsy findings available completion of cause of
Vital Prician: The Certificate	director, p	Bec	25. Was case referred to medical examiner?				26. Place of Death			
Of V Physic this o	ō	P	1 ☐ Yes 2 ☑ No 27. Manner of Death		ent 2 ER/Outp		41 Anursing Ho	me 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spec	cify)
VISION Of VITA Attending Physician: If death.		tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) Inju	iry Woi	rk? Yes 2 □ No	200. Describe nov	w injury occurred	
Divisi or Atten after deat	in by the	Certification:	3 Suicide 6 Could not b	e 28e. Place of Inj	ury - At home, farm c. (Specify)	, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
ospita hours		edical Ce	(Check only 2 Medical Exar	niner: On the basis o	f examination and/	death occurred at the tile or investigation, in my d	me, date and place, a ppinion, death occurr	and due to the car ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To the H within 24 To the Fi	omple	Med	one) 29b. Signature and title of certifier	and manner st	ated.	29c. Licens	se number	29	d. Date signed (Monti	n, Day, Year)
F 3 F	0		> plural &	een		1+	45931		June 6	2006
R (2	-)		30. Name and address of person who	completed cause of o	leath (Item 23a) (T	70 Park	Height	Avend	e Balti	ZOOG MONE, MD
R	Sta egistr		31. Date filed (Month, Day, Year) JUN 0 8 200		ar's Signature	meli	,		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** WATERS ELWOOD LEVIN 0635 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death Examiner alisbury Monico egional Medical Center If Under 24 H If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year, **Funeral** Days Hours 1 XM 2□F 214-34-7477 Yrs. Oct. 24, 1912 Maryland Director 93 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f ehov traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Snow Hill Maryland Worcester Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21863 429 Covington Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 XNo Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Farming self-employed 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit Pages 1 and 2 should be.
Department of Health and Mental H
Important: If item 27 is mearty injury or other-2 should be fi and Mental H is marked of Truitt Waters Aline Hasty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 429 Covington Street - Snow Hill, Maryland 21863 Ruby Waters/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/19/2006 Ebenezer UMC Cem. Snow Hill, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service Licensee Jolley Memorial Chapel 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause diveach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 30 mu /Medical Due to (or as a constituence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit noumonia that initiated events a ed by the attending physician and detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 Minknown Completed 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 NO 1 Yes 2 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3□ DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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41-48-4C

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egistrar's Signatura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

-20050

	1 - For State Registrar		artment of Health and M <i>rtificate of Death</i>	lental Hygier Reg. 1		3835
Physician	1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Tin	ne of Death
/Medical Examiner	Margaret Veronica V 4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Death	June 3	2006 11:3	33A M
W. 2 3 4	Doctor's Community		Lanham		Prince George	
Funeral Director	5. Social Security Number 220-64-8131 Usual Residence of Decedent	7. Age (In yrs. last birthday) 2 X F 50 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 08/17/195	9. Birthplace (St Country) Maryland	ate or Foreign
laryland show show	10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Insid	de City Limits
hit the Man a or 28a-f at the notified Director	Maryland Prince Geo	orge's Bowie			10	Yes 2X∏No
with the Man or 2 as or 2 liberal libire	10e. Street and Number 9513 Old Laurel-Bown	o Pond	10f. Zip Code 20720	10g. (Citizen of What Country?	
6 Safer death virtems 23 culturer man	11 Marital Status 12.	Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - American India	n,
Z 83 × ×	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2.ADANo	1 ☐ Yes XXNo Specify:	nican, etc.)	Black, White, etc. Specify: White	
21215-00 ed within 72 hou syglene. In the Marie It. It is the completed Completed	15. Decedent's Educati (Specify only highest grade co	on 16a Dece (Give	dent's Usual Occupation kind of work done during most of working	ng IIn	Kind of Business/Industry ited Associat	ion of
Ind 21215-(be filed within 72 half- d other than matter event, the Modes Be Complete	Elementary/Secondary (0-12)	College (1-4or 5+) Manäge 6 Inform	sents usual Occupation kind of work done during most of workin DO NOT use retired) Er of Membership nation Services	Pli	umbers & Pipe	
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(= c = 0 =	Edgar Warren Wiggins		Old Laurel-Bowie			
lore, lore, and to the tree or other	20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Rem	20b. Place of Dispo cemetery, crer First	sition (Name of Datory or other place) Lutheran	ate 20c.	Location - City or Town, State	Э
Baltimore Baltimore permit. Pages Department of tell Important: If its any injury or ot once.	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fusing Service Licensee	Church	Cemetery 06/08	/2006 Box	wie, MD	
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Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	1ty pertens	2.		Onset a	nd Death
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sit sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a consequence of):				
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ox 60 certific ding p	IF FEMALE: 23c	If yes, outcome of pregnancy				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification; To Be Completed by Physician/Medical Examir	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day	Year
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tal F an: Th utilicate or, pag	25. Was case referred to medical			performed? 1 ☐ Yes 2\(\)XN	death?	
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Division of Vital Records, P.O. teal or Attending Physicien: The law requires that the district cearth. Director: After this certificate has been signed by the ed in by the funeral director, page 2 should be detached Certification; To Be Completed by Physic	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home, farm, stre	M 1 Yes 2 No eet, factory, office 2	Bf. Location (Street a	nd Number or Rural Route N	umber,
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thin 24 house the Hose thin 24 house the Fune fune fune fune fune fune fune fune f	Z Induction Canifolia.	In: To the best of my knowledge, death On the basis of examination and/or invalid manner stated.	occurred at the time, date and place, are estigation, in my opinion, death occurred	nd due to the cause(s d at the time, date an	and manner as stated. d place, and due to the caus	Θ(S)
To the within To the comple	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year	-)
	Jam E oll	as C	m0030858	June	3 2006	
	30. Name and address of person who compl	oted cause of death (Item 23a) (Type, I	Street Syite 351	Lourel	MD BATA	7
State	31. Date filed (Month, Day, Day) 0 7	Register's Signature	Soule !	1-441-1	, 4070	/

State of Maryland / Department of Health and Mental Hygiene 2 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Dennis Craig Walston 2006 June 5, 10:35A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8020 Hawkins Creamery Road Laytonsville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 30, 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 219-64-5864 53 1953 New York Usual Residence of Decedent deeth with the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Montgomery Laytonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? r than "naturel", or Iteme 23a or the Medical Examiner must be 8020 Hawkins Creamery Road 20882 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. t ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Artist Art marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude E. Walston 2 Betty Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark L. Walston - Brother 4340 Leeds Hall Drive, Olney, Maryland 20832 Important: If its eny injury or oth ones. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State t ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metropolitan Crematorium 06/06/06 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home Silliam 26401 Ridge koad, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gunsho Immediate Cause (Final Physician Wound disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → o 24a. Was an autopsy perform certificate 1 Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After th funeral 28a. Date of Injury (Month: Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 106 wouha death. 1 Yes 2 No aunsho investigation 2 Accident efter deat 3 Suicide 4 Homicide 6 Could not be determined Place of Injury - At home, form, street, factory, office building, etc. (Specify) à OME Creamery within 24 hours e kd, Garthersbur Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cluse(s) and manner as stated. 29a. Certifie (Check only one) 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) ucia Roch Ville Pi 30. Name, and address of person who completed cause of \$1. Date filed (Month, Day, Year) 32. Resstrar's Signature State Registrar

Warlick, Moutha

For State Registrar

1. Decedent's Name (First, Middle, Last)

Physician Martha Inez Warlick 10 2006 1430 une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton labot Memorial Hospital Easton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,)
June 13, 6. Sex **Funeral** Months Days 1 M A F 86 219-22-7751 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State or 28a-f show the Madical Examiner must be notified at MD Caroline Denton 1 Yes 2 No Director 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21629 410 Colonial DRive "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: caucasion ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) than. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If Itam 27 is marked other ther eny injury or other traumatic event, the Mones. Lamily homemaker 11 H.S. grad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dunmier Elizabeth Blanche Francis Charles Miller ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) 9519 Moreland Drive, Denton, Maryland 21629 19a. Informant's Name/Relationship (Type, Print) Susan A. Cianchetta Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Capitol Crematory 6/12/2006 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Sanatur of Funeral Service 22. Name and Address of Facility Moore Funeral Home, PA, 12S. 2nd St., Denton, ND 21629 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rend Physician /Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itiated events resulting in death) Last (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 🗆 No 9 Unknown sete has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Impatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 5 Pending investigation 1 Adjural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I 1 __ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 __ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of perion who MY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death

2. Date of Death

Month

Day

Year

3. Time of Death

Registrar DHMH 17 Rev 1/2001

State

lave

31. Date filed (Month, Day, Year)

JUN

NEGRAS NAVA

- 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600

32 Registrar's Signature

D0062448

NORTH WOLLE STREET, BAUTISTORIE

JUNE

2006

MD 21287

DI Vestion	20	1 - State Registrar AMEND #23u, 23 PAR 1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Reg. No. uth Day Ye	3. Time of Death
Physici /Medic		Charles William	Young					5 2006	9:45am
Examir		4a. Facility Name (If not institution, give		4	b. City, Town, or Loc	ation of Death		4c. County of D	
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uneral irector		219-42-4008	7. Age (In yrs. last I			Under 24 Hrs. ours Min.	8. Date of Birti (Month, Day Feb. 18	(, Year)	Birthplace (State or Forei Country) Shancton DC
2		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Local	tion				10d. Inside City Limit
eho a	5								1 Yes 2X1
if item 27 ie marked other then "naturel", or items 23a or 28a-1 ehow or other traumatic event, the Mudical Examinar must be collined at	Director	Maryland Charles 10e. Street and Number		Walc	10f. Zip Code			10g. Citizen of What	: Country?
3a or		1124 Hamlin Road			206	02		1	S
E	nera		12. Was Decedent Ever in U.S. Armed Forces?	13. Wa	s Decedent of Hispar es, specify Cuban, N		ecify Yes or No-		merican Indian, /hite, etc.
or the	/ Funeral	1 ☐ Never Married 2 ☐ Married	1 XYes 2 ☐ No If Yes, Give			pecify:	riican, etc.;	Specify:	ville, etc.
Exp	Completed by	3 Widowed 4 Divorced	Year or Dates:						White
nati	ete	15. Decedent's Edu (Specify only highest grad	cation 16 e completed)	6a. Deceder (Give kir	nt's Usual Occupation and of work done during NOT use retired)	n ig most of worki	ing	16b. Kind of Busine	ess/Industry
ie marked other then aumatic event, the Ma	m id	Elementary/Secondary (0-12)	College (1-4or 5+)		rity Guard			Pepco	
ot, th		17. Father's Name (First, Middle, Last)		Jecui			(First, Middle,	Maiden Sumame)	
0 0	Be c	Charles Shelby You	ng				anor Co	*	
e marked o umatic eve	ဥ	19a. Informant's Name/Relationship (Ty		9b. Mailing	Address (Street and				e, Zip Code)
z/ re		Marie F. Young - 1	wife :	1124 F	lamlin Roa	d. Wald	orf, MD	20602	
othe		20a. Mathod of Disposition	20b. Pface	of Dispositi	ion (Name of tory or other place)		Date	20c. Location - City	or Town, State
y or		1 th Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		Ep. Cem.	6-9-0	6	Aquasco,	MD
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ledical aminer prize pri	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence DIABET Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence DIABET)	E MEL	LITUS				
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is certificate has l director, page 2 s		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury at Work? M 1 □ Yes	2 🗆 No	28d. Describe h	ow injury occurred	
r: After this certificate he funeral director, page	¥	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (S City or Tow		r Rural Route Number,		
il Director: After this certificate hid in by the funeral director, page	Sertification	4 Homicide determined					, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)		
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			For State	• •	d / Departm	ent of Health and	_	_	19840
			I - State Registrar		Certific	ate of Death	F	Reg. No.	10010
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99	irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆 Ye	as 2. No Specify:		Specify:	AMERICAN
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ă	atter for u	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		ic pregnancy r (specify)		Month	Day Year
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<u>K</u>	er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At he building, etc. (Specify		ctory, office	28f. Location (S City or Tow	Street and Number or Rura	al Route Number,
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•	~		, 200	MD.		D 23300 BON 3EA		JUNE 2	1 2006
	7		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	BON SEAN BALTU.	Lunizs	rest,	2:
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		For State Registrer	State of M	aryland / Dep	partment o				iene (06	19841
Physicia		1. Decedent's Name (First, Middle, LARRY EDW	,	EVINS S	Sr.			2. Date of Deat Month	Day	Year OG	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, ATLANTIC GEN)			BER	RLI			4c. Count		rer
Funeral Director		5. Social Security Number 212563956 Usual Residence of Decedent	6. Sex 7. Ag 1 M 2 ☐ F	ge (In yrs. last birthda 56 Yrs.	Months Da	ays	Hours Min.	8. Date of Birth (Month, Day, SEPT	^{Year)} 30 , 1949	9. Birthp Cour W •	olace (State or Foreign ntry) Virginia
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yland Suld be filed Mental Hyg	To Be C	17. Father's Name (First, Middle, LETRUE BLEV	ast)				18. Mother's Name		faiden Sumar		
na a a	ı	19a. Informant's Name/Relationsh DIANE BLEVINS 20a. Method of Disposition 1 ♀ Burial 2 □ Cremation	y WIFE	190 20b. Place of Dis	7 HEML	OCH	D	EDGEWC		D 21	040
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or other		'4 □ Donation 5 □ Other (Sp 21. Signature of 5 □ Service L	ecify)	GARDEN	S OF F. 22. Name and Ad 1211 Cl	ddress	of Facility CVA	CH/ROS	BALTI	FUN	ERAL HOME
Pnysician		23a. Part 1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each li	d the death. Do not e ne.			SACO AVE such as cardiac o			RE,	MD 21237 Approximate Interval Between Onset and Death
	dicai Examiner	Sequentially list conditions, if any, leading to immediate base. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Scor-	a consequence of): a consequence of): a consequence of):	ric	Cc	Clion	n 2			6 moRs
9/3c// 6/7c/2c O. Box 68 The death certification of the attending of the death of the contraction of the death of the d	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregni □ Other (s <i>pecif</i>)					te of delive	ery Day Year
S, S, S, S, S, S, S, S, S, S, S, S, S, S	þ	Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cause	e given	in Part I.		acco use cont	tribute to th	ne cause of death?
556 DeVINS DeVINS DeVITAI RECORDS, Iclan: The law requires tector, page 2 should be rector, page 2 should be	Completed							24a. Was an autopsy perform	ed?	prior to cor death?	psy findings available inpletion of cause of
3 55/2 of Vita	To Be	25. Was case referred to medical examiner? 1			of 28c. I	Other Injury a Work?			nce 6 Oth		()
or Attanuiter death	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	ot be 28e. Place of Inj	ury - At home, farm, s c. (Specify)		-	es 2 □ No 2	8f. Location (Str. City or Town,	eet and Numb State)	er or Rura	l Route Number,
ha Hospi n 24 hou ha Funar pletely fill	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To To Conn	<	29b. Signature and title of certifier	ILC.	D.0		4	4283		d. Date signe 6/20 Berli	/	
V		30. Name and address of person with the state of the stat		leath (Item 23a) (Type 3 + 33	Fezint)	n 2 i	1 Drin	e i	Berl,	11	ND
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 5

					, i.a., y i.a.	Cer	tificate c	f Death		Rag. No.	JUD	1904
			1. Decedent's Name (First, Midd.	le, Last)					2. Date of E	Death	V	3. Time of Death
	Physic /Medi		Beatrice Vio	la Buttle	S				June	13, 2006	Year	12:45 PM
	Examir		4a. Facility Name (If not institutio	n, give street and numbe	r)			4b. City, Town	, or Location of Dea	ath 4c. Count	y of Death	
1			Brook Grove Nu	rsing Cente	r			Sandy	Spring	Mont	gomer	У
	Funeral		5. Social Security Number	6. Sex 7. / 1 ☐ M 2 🖾 F	Age (In yrs. I		If Under 1 Ye Months Da		Min. (Month, L	lirth Day, Year)	Count	lace (State or Foreign
	Director	l	009-14-3745 Usual Residence of Decedent	7.3.111	85	Yrs.			Mar.	12, 1921	Verm	ont
	and and		10a. State 10b. County		10c. City	, Town or Lo	cation				10	0d. Inside City Limits
	Marylan f show	ō	MA Essex		Nort	burypo	rt					1)X Yes 2 □ No
	the Me	5	10e. Street and Number		News	bulypo	10f. Zip Cod			10g. Citizen of	What Count	trv?
	ith with the Maryla 23e or 28e-f shoust be notified at	□	207 Water Stree	t			01950				. A .	,
	death ms 2	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U,S	S. 13. V	Vas Decedent of	f Hispanic Origin	? (Specify Yes or N		ce - America	an Indian,
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23e or 28e-f show eny Injury or other treumatic event, the Medical Examinating India and once.	Ď	1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	No		Yes, specify C		Puèrto Rican, etc.)	Speci.	ack, White, e fy: Whit	
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pu	be file	Be	17. Father's Name (First, Middle,	Last)					Name (First, Middi	e, Maiden Sumai	me)	
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Jar	2 sh and Is m	1 13	19a. Informant's Name/Relations						or Rural Route Num			Code)
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9	ges 1 t of H If Itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Stat	e ce	emetery, crem	sition (Name of natory or other p	•	Date	20c. Location		
틆	Pa men men men men men men men men men men		4 ☐ Donation 5 ☐ Other (S		Met			ematory		Alexan	dria,	VA
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. line.	. Do not ente	r the mode of o	ying, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician											Onset and Death
J.	/Medical Examiner		Immediate Cause (Final disease or condition	Guoi	BLAST	FOMA					(6 MONTHS
н	LXUIIIIICI	L.	resulting in death)		Due to (or	as a consequ	uence of):					•
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	To the Hospital or Attend within 24 hours effer death To the Funerel Director:		29a. Certifier 1 Certifyln	g Physician: To the best Examiner: On the basis	of my know	ledge, death	occurred at the	time, date and pl	ace, and due to the	cause(s) and ma	anner as stat	ted.
	n 24 n 24 ne Fu	edical	(Check only 2 Medical I	Examiner: On the basis and manner s	of examination tated.	on and/or inve	estigation, in my	opinion, death o	occurred at the time,	date and place,	and due to th	he cause(s)
	To the Hospital of within 24 hours elements of the Funerel Department of the Funerel Department of the Funerel Management of the Funerel of t	Σ	29b. Signature and title of certifier				29c. Lice	nse number		29d. Date signe	d (Month, Da	ay, Year)
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	U		TED E. HOWE	154 N. A	ASITS	N ST	. WIL	LIAMSPO	ET, ME	2179	5	
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	Registr	ar	JUN 2 3	2006	w D	1400	MEL					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 19,2006 June 9:35 P **Physician** JANE BOYD /Medical 4b. City, Town, or Location of Death Towson4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Examiner Gilchrist Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 18, 1934 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 72 1 ☐ M 2 🕱 F Michigan 367-32-5062 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Baltimore MD 1 ☐ Yes 2X No Director the 10f. Zip Code 21 234 10e. Street and Number 10g. Citizen of What Country? 3044 Parktowne Road USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced al Hygiene. d other than "natural event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired! Insurance Clerk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry St. Paul Travelers Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 27 is marked or treumatic ever Anna Siembor Sebastian Miedlar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22692 Ennishore Drive-Novi, Michigan 19a. Informant's Name/Relationship (Type, Print) 48375 permit. Pages 1 and 2::
Department of Health at important: If Item 27 is eny injury or other treugons. Christine Wilke-sister Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 6-21-06 Parkville, Maryland M01448 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service License 2. a. Part: Enter the issease, in the factions that cause in each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset an Death Immediate Cause Final Congestove **Physician** an resulting in death) /Medical Due to (or as a consequence of) Examiner schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? d ise ase 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 ☐ Yes 2 TNo 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 20, 2006 125205 (uno who completed cause of de fill frem 23a) (Type, Print) 30. Name and address of person N. Charles St. Bolts. M& Z120x 6701 32. Aggistrar's Signature 31. Date filed (Month, Day, Year) State JUN 23 2006 Registrar

JUME 19,

21215-0036

Maryland

Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ () () 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Heartlands of Ellicott City Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 86 Yrs. 200-10-7223 JUNE 9 1920 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 N. Ridge Road 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Restaurant Elementary/Secondary (0-12) College (1-4or 5+) 12 Equipment Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William John Boone Sarah Ridgely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Steib - daughter 5761 Old Landing Road, Elkridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory | 6/22/2006 Beltsville, MD ²²CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, T Towson, MD21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Athersclendu Cardiovescular Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Varcular Discare 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐ Pregnant at time of death Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Inpatient 2 TER/Outpatient 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Yes 2 No 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner led by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical has Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be Certification:

Physician

/Medical

Examiner

Director

by Funeral

Completed

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mudical Examinat must be notified at

Hygiene.

Pages 1 and 2 should be filed witnest of Health and Mental Hygien tant: If item 27 is marked other theiry or other traumatic event, Ills

permit. Page Department o Important: If any injury or once.

Physician

/Medical

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

4 | Homicide

29a, Certifier

6 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Balhour

(Check only one) 29b. Signature and title of certifier 6 anne

29c. License number D30641 29d. Date signed (Month, Day, Year) June 21

Mary land 21221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back RIVER WICK ROad

Sabapalmi 31. Date filed (Month, Day, Year)

JUN 2 3

State Registrar

To the Hospital within 24 hours a To the Funeral E

State of Maryland / Department of Health and Mental Hygiene 2 [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death **Physician** 20, June 2006 8:10 РМ Connie Marie Betancourt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, October 9, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) 1951 **Funeral** Days Months Hours 1 ☐ M 2 🖾 F Tennessee 54 Director 220-58-9695 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ital Hygiene. Indother than "netural", or Iteme 23s or 28s-1 ehow event, the Mindical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 United States 8209 Shady Spring Drive permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Iteme 234 any Injury or other traumatic event, tra Mudical Exercities found 2008. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Beulah Mae Webster Not Available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodolfo Betancourt /Husband 8209 Shady Spring Drive, Gaithersburg, MD 20877 June 22, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Myelette Barrot 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shockfor heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ~6 months disease or condition resulting in death) Small (ell Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initial orders cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Dualto (or as a consequence of)al or Attending Physician: The law requires that the death certificate be executed to effer death.

I Director: After this certificate has been signed by the ettending physicien and din by the funeral director, page 2 should be detached for use as the harman to the funeral director. Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2⊠No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eff To the Funeral Dicompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Tune 21,2006 Paul Barren MD MD 60335 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince # 327 Barren 18111 Olney MO anl 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 3 2006 Registrar

18 Mother's Name (Pines, Medice, Late) 18 Mother's Name (Pines, Medice, Late) 19 Mother's Name (Pines, Medice, Late) 19 Mother's Name (Pines, Medice, Late) 19 Mother's Name (Pines, Medice, Late) 19 Mother's Name (Pines, Medice, Late) 19 Mother's Name (Pines, Medice, Late) 19 Mother's Name (Pines, Medice, Medi				For State Registrar	State of Marylan		artment rtificate				giene Reg. No		19846
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul (Lite 900 Contain Avenue, Baltimore, MB 21229)	ŏ	th cert lendin r use	an/M	23b. Was decedent pregnant			Ectopic pre	egnancy					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul (Lite 900 Contain Avenue, Baltimore, MB 21229)	о П	ne dea the at hed fo	sici	1 ☐ Yes 2 ☐ No		eath 5	Other (spe	ecify)				Month	Day Year
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul (Lite 900 Contain Avenue, Baltimore, MB 21229)	ds	quires n sign ald be		Hypertension	Diabet	es,	Per,	phi	i-onl	1 🗀	Yes 2	□No 3□Pro	bably 4 Unknown
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul (Lite 900 Contain Avenue, Baltimore, MB 21229)	Ĕ	The II	mo							perfe	ormed?	death?	
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A Section of Country May Depart of May Depart of		Director			1 2 4 7	85 Yr	S.					_
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Physician disease or condition and disease or				23a. Party. Enter the disease, or complica shock, or heart failure. List only one	cause on each lin	θ.	t enter the mode of dy	ring, such as cardiac	or respiratory a	rrest,		Interval Between
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Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. Part II. Other significant conditions contribute to the cause of death?	9		00	d								
Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. Part II. Other significant conditions contribute to the cause of death?	30X	ath cert tendin or use	an/N	23b. Was decedent pregnant 23c	1 ☐ Live birth	2 Fetal death	3 ⊟Ectopic pregnan	су				•
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	o.	he des	ysici			time of death	5 Other (specify)			Mor	uı	Day Year
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	(6)	Hospita 24 hours Funere tely fille	lical C	(Check only 2 Medical Examine)	: On the basis of	examination and/	death occurred at the to investigation, in my	time, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mar date and place, a	ner as sta	ated. the cause(s)
		Fo the vithin ?	Mec	0/10/	anu manner stat	teu.						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G-EORCE N. KARKAR MO 6565 N. Charle, 5t. suit-615 TOW 30 N MO State 31. Date filed (Month, Day, Year) 11. N. 2. 3. 2006 11. N. 2. 3. 2006		- 3 - 0		Grage N. Car	Kann	D	D16	189		6/21	120	06
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10		30. Name and address of person who comp	pleted cause of de	eath (Item 23a) (Ty	(pe, Print) 6565N	Charles?	st_suce	615 10	WID	~ MD
	15	Sta Registr		31. Date filed (Month, Day, Year)	32. Regulra	r's Signature	boute					

			For State Registrar	State of Maryland	-	artment of Heatificate of De			ene 0 0	5 19848
6			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
15.	Physici		Jermaine		C	romwell	(June	17 200	A 3 6 0 11 1 11 11 1 1 1 1
. 2	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or Lo			4c. County of D	
No.			The Johns Hoph	Kins Hospita		Baltimor	e City		N/A	
- `	Funeral	0	5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year II	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear) 9.1	Birthplace (State or Foreign Country)
	Diréctor	ië ,	Usual Residence of Decedent	37	Yrs.			Nov 25,	1968	Maryland
	/land		10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. Inside City Limits
	Man a-f sh	tor	Maryland N/A		Balti	lmore				1 X Yes 2 ☐ No
	th the	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	23a	rai	1410 Stonewood Roa	d		21239	9		USA	
	tems	by Funeral Director		Was Decedent Ever in U.S. Armed Forces?		Was Decedent of Hispa f Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	', or I	y F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		I□Yes 2∏ No 5	Specify:		Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Macieral Exercites must be collified at	ed	15. Decedent's Educa	ation	16a. Deced	lent's Usual Occupation	on	16	6b. Kind of Busine	Black ss/Industry
215	hin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done duri DO NOT use retired)	ing most of workir	ng		,
2	giene giene	Соп	12		Nursi	ng Home Su	perviso	c	Health	Care
nd	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	Be	17. Father's Name (First, Middle, Last)			18	3. Mother's Name	(First, Middle, Ma	aiden Sumame)	
yla	Men Marke Marke	ဥ	Harold J.		Sr.		Lucille		Traf	
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Typ			g Address (Street and				
d)	1 and 2 Health em 27 l		Lucille Cromwell/M 20a. Method of Disposition	20b. Plac	ce of Dispo	Stonewood			e MD 2.	1239 or Town, State
nor	ages ant of it: if lt y or c		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donatton 5 ☐ Other (Specify)	moval from State	-	natory or other place)	6.100		,	,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examiner must be notified at Once.		21. Single of uneral Service License		22	. Name and Address of	of Facility		Sparks,	
ñ	Depa Impo eny Ir		Aryan W. Clary	very ,	1 (mmon Funer W. Padoni	cal Home	of Dulan	ney Valle	ey Inc.
8	- 27	8	23a. Part1. Enter the disease, or complic shock, wheart failure. List only one	a ons that used the death.						Approximate Interval Between
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	/Medical Examiner		resulting in death)	ue to (or as a consequer			1			1 days
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T	led sit	nine	if any, leading to immediate cause. Enter Underlying	LI 1 10	1					20 44 44
Υ_	al-trai	xar	that initiated events c. resulting in death) Last	Due to (or as a consequen		mphoma				20 months
8760,	cate be executed physicien and the burial-transit	dical Examiner	d.							
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Вох	death certific e attending p od for use as	an/N	200. Tras decedent pregnant	c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregnancy			23d. Date of	
Э. Е	0 0 2	sici	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of deat 9 Unknown		Other (specify)			Month	Day Year
P.O.	law requires that the death as been signed by the atter 2 should be detached for r	Physician/M	9 ☐ Unknown Part II. Other significant conditions cont	sibuting to doubt but not squaliti	mm in the co	adauksias aassa suusa t	in Donal	22a Didasha		to the cause of death?
Vital Records,	signed I	1 by	• .	occlusive d			in Fanti.	1 ☐ Yes	11	Probably 4 Unknown
Ö	w requir been si should I	Completed	Trefatic veno-	occiusive a	1709					
Re	0 5 6	dmo						24a. Was an autopsy performe	prior t	autopsy findings available o completion of cause of ?
tal	ician: Th certificete rector, pag	မ C	25. Was case referred to medical			26	6. Place of Death]No 1□Y	es 2 No
	nding Physician: th. : After this certifice s funeral director,	To B	examiner?	spital: 1 💢 Inpatient 2 🗆 EF	VOutpatien	Other			ce 6 □Other (S	pecify)
pivision of	ng Ph ter th neral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of	28c. Injury at Work?		8d. Describe how		
Sio	Attending ir death. ector: After by the fune	atic	2 Accident investigation				2 □ No			
Ξ̈́	or Ati fter d Direct in by	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eat, factory, office	2	8f. Location (Stre City or Town, :		Rural Route Number,
	pital ours a eral [29a. Certifier 1 X Certifying Physi	cien: To the best of my knowle	adge deeth	coourad at the time	data and place a	ad due to the seco	/-)d	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A cumpletely filled in by the fu	edical	(Check only 2 Medical Examine one)	Fr: On the basis of examination and manner stated.	n and/or inv	restigation, in my opini	on, death occurre	d at the time, date	and place, and d	ue to the cause(s)
/	To the	Me	29b. Signature and title of certifier			29c. License nu	umber	29d	. Date signed (Mo	nth, Day, Year)
)			Nadeen Hoseir	1. Medical D	octor	RES	- 000	J	une 17,	2006
	3					Print)	77.1	2 10 4 5	,	
100			30. Name and address of person who con No pen Hospin 6 31. Date filed (Month, Day, Year) JUN 2 3 200	00 North Wo	Ife S	street, Be	altimore	Mary	land,	21287
	Sta Registr	ite	31. Date filed (Month, Day, Year) /	32. Figistrar's Signatur	4 1	mesti)		'	,	
400	ricgisti	GII	30M 9 9 200	THE CONTROL OF	1					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	tificate of	Death		Reg	g. No. 200	6 1984
Physici		Decedent's Name (First, Middle,Last)					Date of Death Month	Day Year	3. Time of Death
edical Exami	iner		rt Joyce Crow				June 19, 20	006	1100 hrs
		4a. Facility Name (if not institution, give Suburban Hospital	street and number)	44	D. City, Town, or Lo Bethesda	ocation of Death	1	4c. County of Death Montgomery	1
		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast histhday)	If Under 1 Year	If Under 24Hrs	No Date of Birth		that are (Otal)
Funeral Director				ast birthday)	Months Days	Hours Mir).	n(MM/DD/YYYY) 9. Bir Foreig	ın
Billootor		214-48-5158	/ 2 F 5	7 Yrs.		L	December	: 17, 1948 Was	hington, D.C.
any		Usual Residence of Decedent 10a. State 10b. County	I10c City	Town or Locatio	n				10d. Inside City Limits
÷ 1			, see Suy,						1 Yes 2 X No
Maryland 28n-f show d at once	tor	Maryland Montg 10e. Street and Number	omery	Т	10f. Zip Code	ethesda		- Citi	
e Mar or 28; ied a	Director	Toe. Greet and Number			Tot. Zip Code		10	g Citizen of What Cour	itr y ?
ith th 23a notif			arkhill Drive	0 140 146		0814		Unites	
ath w	Funeral	1 X Never Married 2 Married	Armed Forces?	o. If Yes	Decedent of Hispa s, specify Cuban, N	nic Origin? (S Mexican, Puerto	Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
or de		3 Widowed 4 Divorced	1X Yes 2 No Yes, Give Year Vietnam		res 2 X No	snecify:		Specific	
irs afi tural'	l by	15. Decedent's Education (Specify only			Usual Occupation		work done	Specify: 16b. Kind of Business/I	White ndustry
72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		st of working life, D				
136 thin ne	npl	12			Cle	rk		Ret	ail
5-0(ed wi tygien other	Cor	17. Father's Name (First, Middle, Last)	,				e (First, Middle, Ma		411
21215-0036 Juld be filed within 7 Mental Hygiene marked other than	Be	Robert Jo	oyce Crowley,	Sr.			Eleano	ra Henius	
21 nould id Me is ma tic ev	ပ	19a Informant's Name/Relationship (Typ	pe, Print)	19b. Mailing	Address (Street a	and Number or I	Rural Route Numb	per, City or Town, State	Zip Code)
MD and 2 sho m 27 is aumati		Eleanora Crowley		9224 E	ast Park	hill Dr	ive Beth	esda. Marv	land 20814
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland and of Health Monel Higd within 72 hours after death with the Maryland and Fleating is marked other than "natural", or items 33a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.		20a Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	rematory or othe	on (Name of ceme r place)	tery,	_	20c. Location - City or	Town, State
Page Page Tent o		4 Donation 5 Other Specify:	- I (Gate of Heave	n Cemete	rv 23	June 2006	Silver Snri	ng,Maryland
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite		21. Signature of uneral Service License		22. Na	me and Address o	f Facility Rob	ert A. P	umphrey Fu	neral Home/
@ 82 = E		Xen) 1	epour 1 MOO3	335 Bet	hesda, M	aryland	20814-3	501 Wisc	neral Home/ onsinAvenue
Physician		23a. Part I. Enter the disease, or complete failure. List only one cause on each	altons that caused the death.	Do not enter the	mode of dying, su	ich as cardiac d	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	9 N	Immediate Cause (Final disease a.	Multiple inju	ıries					Death
		or condition resulting in death)	ue to (or as a consequence of	").					
man of	70	Sequentially list conditions, b if any, leading to immediate Di	ue to (or as a consequence of	·)·					
	Examiner	cause. Enter Underlying Cause	20 (0) (0) (0) (0)	7-					
sit. d	xar	events resulting in death) Last	ue to (or as a consequence of):					
executed an and al - trans		d	item#1 2	32 27 292	-f,perME,g	0E7 7/00/	/OC 1777		
760, Trate be executed physician and the burial - transit	n/Medical	LA.			-r,perrin,go	557,77207	U0 11		
Box 68760, death certificate be the attending physicil d for use as the buri	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr		I death 3	Ectopic pregns	ancy.	23d. Date of delivery Month D	ay Year
Box 68 te death certi the attendin ted for use a	cial	past 12 months?	4 Pregnant at time of de		(Specify)	Letopic pregne	шы	Month	ay Year
Bo deat	Physicia	1 Yes 2 No 9 Unknown	9 Unknown						
P.O. es that the igned by be detache		Part II. Other significant conditions	ontributing to death but not re	sulting in the un-	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
signe be d	d by						1 Yes	2 No 3 Prob	ably 4 Unknown
reque peen peen peen peen peen peen peen pe	Completed						24a Was an		opsy findings available ompletion of cause of
e law te has	Ĕ						perform	ned? death?	
n: The Triffical or, pa		25. Was case referred to medical			26 Place of	Death (Check	1 Yes 2	No 1 Yes	s 2 No
/ita	Be c	examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient		hor		esidence 6 Other:	
Division of Vital Records, P.O. Box 687 and or Attending Physician: The law requires that the death certificate death certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as it.	5	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Inju	ury 28c. Injury a			w injury occurred	
	ţi	1 Natural 5 Pending	6/19/2006	10:14 am	1 Yes	3 2 No	struck by t	train	
r Atte	fica	2 X Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At ho						al Route Number, City
Division pital or Attencours after death	Certification:	Suicide 6 Could not be determined		d tracks			Kensington	n, MD Metrop	al Route Number, City politan Avenue
Hosp 24 hor Fune tely fi		29a Cartifier	: To the best of my knowledg	ge, death occurre	d at the time, date	and place, and			
Divisior To the Hospital or Attend within 24 hours after death To the Funcral Director:	Medical	one) 2 Medical Examiner: 0	On the basis of examination are						
F 3 F 8	Me	29b. Signature and title of certifier			29c. License r	number		29d Date signed (Mon	th, Day, Year)
D.			11/	-	O.C.M.	E.		June 21, 2006	ė
2 N	- 8	30. Name and address of rson who co	mpleted cause of death (Item	23a)					
10 by		Jack Titus MD. Deputy C	hief Medical Examiner	111 Penn	Street, Baltim	nore, MD 21	201		
S	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re de la company	-				
Regis	trar	JUN 2 3 2006	MERNES AF	Appelle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#11,19a.perFH.0856,6/23/06 TT.

		Registrar 1. Decedent's Name (First, Middle, Last)		06	rtificate of	Death	2. Date of Death	g. No.		3. Time of Death
Physici /Medic		JEFF		CHEF	RNYAKHOVS	KY	Month	Day	Year 2006	2305 PM
Examin	_	4a. Fecility Name (If not institution, give s				r Location of Death		4c. Count	y of Death	
	g Klube	5+. Agnes Ho	SPITAL	s. last birthday)	Bal-	If Under 24 Hrs.			TIMOR	
Funeral Director			M alle	s. last billiday)	Months Days	Hours Min.	8. Date of Birth (Month, Day, 06/02/19	^{Year)}	Coun	lace (State or Foreign try) UKRAINE
pu .		Usuel Residence of Decedent 10a, State 10b, County		City, Town or Lo	position				1	0d. Inside City Limits
death with the Maryland rme 23a or 28a-f ahow rmat be rediffed at	o	MD BALTIMO		OWINGS					1	1 Yes X No
r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Coun	itry?
th with	ai D	5000 HOLLINGTON DR	IVE APT. #10)2	21117			U.S	S.A.	
be filed within 72 hours after death with the Marylan delity gions. delity gions. delity than "natural", or Iteme 23a or 28a-f ahow event, tre Madical Examination must be rediffed at	by Funeral	11. Marital Status 1 Never Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americ ack, White, fy:	
72 ho 'natur	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	ation during most of worki	ing 1	6b. Kind of E	Business/Inc	dustry
within ene. than "	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use <i>retired</i> F CHMAKER	d)	l l	JEWELF	v	
Hygin other	Be Cc	17. Father's Name (First, Middle, Last)		, WA	CHIMAKLK	18. Mother's Name				
	To B	JOSEF	CHEF	RNYAKHO\	SKY	SONY		VACHU	JTINSK	AYA
d 2 should th and Mer 7 is marke traumatic	5 6	19a. Informant's Name/Relationship (Type				and Number or Rura				
ges 1 and t of Healtl If Item 27 or other 1	i iš	VERA MUDRIK / WIFE 20a. Method of Disposition	20b		Sition (Name of matory or other place	N DR. #10		00. Location		
Pages lent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crei R SINAI			/2006 0		-	
permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License		22	2. Name and Addres	ss of Facility SOL ERSTOWN R	LEVINSO	N & BR	os.,	INC
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the e e cause on each line.	ath. O ot ent	er the mode of dyin	ig, such as cardiac o	or respiratory arre	St,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	Culd	U Kes	restory	Awest			1	set and Death
/Medical Examiner		rosoning in dodain)	Due to (or as a orns	equence of)	Ten				,	14.11
ALL S	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a cons	ce of):	0.11		•		_	T MONEY
and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Jucta	STATIC	Billia	-4 (WC)	hong			3 yrs
physician and sthe burial-transit	al Ex	Tosuling in dolliny cast	Due to (or as a cons	equence of):						\cup
incate be execut physician and is the burial-trar	edicai	d								
neath ceiming in a stending i	an/M	in the past 12 months?	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tel death 3	Ectopic pregnancy Other (specify)	,			ate of delive onth	ry Day Year
ned by the a	Physic	9 ☐ Unknown Part II. Other significant conditions con		aculting in the u	nderhing cause an	an in Part I	23e Did tob	acco use con	utribute to th	e cause of death?
taw requires that as been signed in 2 should be detailed	ted by		anouning to double out not					2 No	3 Proba	.
ine ate h page	Completed						24a. Was an autopsy perform 1 Yes 2		Were autop prior to con death? 1 Yes	osy findings available inpletion of cause of
Pnysician: In this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		oth	26. Place of Death				
After	tlon: To	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injun Worl	4 Li Nursing Hor	me 5 Resider 28d. Describe how			"
il or Attending after death. I Director: Afte I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At building, etc. (Spe		eet, factory, office		28f. Location (Stre City or Town,		ber or Rurai	l Route Number,
To the Hospitel within 24 hours a To the Funeral C completely filled i	edical C	29a. Certifier (Check only one)	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, deatl nation and/or in	occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the car ed at the time, da	use(s) and m te and place,	anner as sta and due to	ated. the cause(s)
To the within To the compli	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signe	ed (Month, L	Day, Year)
		1 Taffer toller	M		1355	625	0	lune à	20,2	006
			/							
10		3d. Name and address of person who co	mpleted cause of death (It	ет 23a) (Туре,	Ory Place	e, Stede	D, Ba	Hima	ve, L	006 0200/

CHELLY AKHOUSKY

		•	- For Amend Item	23a per	Maryland / Dr., C857	Depar Offiz Certi	tment 7/06 ficate	dhip of L	ealth a D <i>eath</i>	nd M	ental H	Hygier Reg. r	1 0 200	6	198	351
	Physici /Medic	an	1. Decedent's Name (First, Middle, L							Ī	2. Date of	Death	2006 Yea		8:30	Death A M
	Examin		4a. Facility Name (If not institution, g Shady Grove Adve			4			Location o			4	4c. County of D Montgor			
	Funeral Director		246-81-6111	Sex 7. 1 □ M 2 🔀 F	Age (In yrs. last b		If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of (Month) May 1	Birth Day, Yea 5, 1	9. 1 922	Birthplace Country) Indi	e (State oi .a.	r Foreign
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	merv	10c. City, Tov		ation	rshi	120			~~			Inside Cit	
	a or 28a-	i Director	10e. Street and Number 18529 Reliant Dr				10f. Zip (Code	0879			10g. (Citizen of What		?	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or Items 23a or 28a-f show event, tre Medical Exertine must be rudified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decede Armed Force 1 _ Yes _ Give Year or Date	es? ⊠No		as Decede res, specif		spanic Orig n, Mexican Specify:	in? (Spe , Puerto l	cify Yes or Rican, etc.	No-	14. Race - A Black, W Specify: As	hite, etc.		lan
21215-0036	rithin 72 hou ne. han "nature e Medical E	Completed b	15. Decedent's (Specify only highest g	Education	16a	life. DO	nd of work NOT use	done d retired)	uring most	of working	ng		Kind of Busine		try	
land 21	be filed ital Hygi of other event, I	To Be Co	17. Father's Name (First, Middle, Las Bhore Lal Gupta	st)		ноп	nemak			r's Name			Own Home (en Sumame)	2		
Maryland	ges 1 and 2 should t of Health and Men If item 27 is marke or other treumatic	-	19a. Informant's Name/Relationship Gharishyam Gupta/			_							y or Town, State g, Maryl			9
Baltimore,	t. Pa tmen rtent:		20a. Method of Disposition 1 Burial 2 Ceremation 3 4 Donation 5 Other (Spec	rify)	20b. Place cemete Montg	ery, crema omery toriu	itory or oth	ner place	1 2	June 2006	•	Ве	Location · City	, Mai		
Ba	permi Depar Impor		23a. Part1. Effer the disease, or co	<u> </u>	M00198	7557	7 Wisc	cons	in Av	e.,		sda,	ome/ (MD 208	Chase 14-3	e. In	ic.
	Pnysician /Medical Examiner		shock, of heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on eac	as a consequence	Pesp of):	irst		F	[]	lur			Int	rerval Between and D	veen
8760, /	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Con	as a consequence gestive] as a consequence	Heart	Fai	lure	+	Fa	de	ve	•			
.O. Box 687	eath certifi attending for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal deat t at time of death		ctopic pre					_	23d. Date of o	delivery Day	y Y	'ear
Δ.	es that gned b	by	Part II. Other significant conditions	contributing to deat	h but not resulting	in the unde	erlying car	use give	n in Part I.				o use contribute	e to the ca		eath? Inknown
Il Records,	The law ate has b page 2 si	Completed									24a. V a p 1 🗆 Ye	utopsy erformed:	? death	to comple	findings a etion of ca	ivailable iuse of
of Vital	Physicien: this certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 XInp	atient 2□ER/C	Outpatient	3□ DOA	Othe	E		(Check or		6 □Other (S	pecify)		
Division o	or Attending Ifter death. Director: After in by the fune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Accident determine	on be 28e. Place of	Injury 28b. Day Year) Injury - At home, 1, etc. (Specify)	. Time of Injury farm, stree	М		at ? ∕es 2 □ N	40	28f. Locatio		jury occurred and Number or ate)	Rural Ro	oute Numb	ber,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai C	29a. Certifier (Check only one) 1 Certifying 1 2 Medicel Ex	Physician: To the beaminer: On the bas	est of my knowledg s of examination a r stated.	ge, death o	occurred at stigation, i	t the tim in my op	e, date and linion, deat	d place, a	and due to ed at the tir	the cause ne, date a	(s) and manner and place, and c	as stated	d. e cause(s)	
)	To t To t	M	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person where the silend (Month, Day, Year) JUN 2 3	roch	· WA	2	29c.	License OOO	624	35		29d. [Date signed (Mo	200	Year)	p
	1		30. Name and address of person who SAYED E 31. Date filed (Month, Day, Year)	completed cause	of death (Item 23a)	7/5	MCO	chile)(en	R S	De. , 1	Rock	ville,	MD	208	550
•	Sta Regist		JUN 2 3	2006	Civil S	fep	enti								<u>.</u>	

		1 - For State o		artment of Health and M rtificate of Death	lental Hygien	CO00 1700C
Physic /Med Exam	ical	Decedent's Name (First, Middle, Last) A	EVAN:	5 4b. City, Town, or Location of Death	MAY -	ay Year 2 2006 0835 M
Funera Directo		a	7. Age (In yrs. last birthday)	LothiAn		9. Birthplace (State or Foreign
<u> </u>		Usual Residence of Decedent 10a. State 10b. County MD Anna Arunde1	10c. City, Town or Lo	thian		10d. Inside City Limits 1 □ Yes 2 No
IIII 4 1 2 13-UU30 be filed within 72 hours after death with the Maryland stal Hygiene. d other than "natural", or frems 23a or 28a-f show event, the Moulcal Examine must be notified at	ted by Funeral Director	Amed For 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Sin Year or D	2 No re ates:	10f. Zip Code 20711 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerlo 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: white Kind of Business/Industry USA 14. Race - American Indian, Black, White, etc.
Maryland Z 1 Z 1 3 2 should be filed within 72 1 and Mental Hygiene. 1s markad other than "m raumatic event, the Mouli	To Be Completed	Elementary/Secondary (0-12) College (*unk* 17. Father's Name (First, Middle, Last)	-4or 5+) life.		a (First, Middle, Maide	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marka any injury or othar traumatic		19a. Informant's Name/Relationship (Type, Print) Anna Arundel Police De 20a. Method of Disposition ¹ □ Burial 2 □ Cremation 3 □ Removal from ⁴ □ Donation 5 ☑ Other (Specify) in sta	20b. Place of Dispo cemetery, creation	osition (Name of matory or other place) 2. Name and Address of Facility tate Anatomy Board	Date 20c. I	Location - City or Town, State
death certificate be executed death certificate be executed www. e attending physician and dor use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	aused the death. Do not entach line. (or as a consequence of): (or as a consequence of): (or as a consequence of): (come of pregnancy lith 2 Fetel death 3	retic Hea		Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year
HECOTOS, P.O. The law requires that the are has been signed by the page 2 should be detached.	te Completed by Physician/M	Part II. Other significant conditions contributing to d	own		23e. Did tobacco 1 Yes 2 24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
DIVISION OF VICA within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	al Certification; To B	27. Manner of Death Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Homicide 28a. Date (Mon Mon 28a. Place (Mon 28a. Place 28a. Place (Mon 28a. Place 28a. Place (Mon 28a. Place 28a. Place (Mon 28a. Place 28a. Place (Mon 28a. Place 28a. Date (Mon 28a. Place 28a. Date (Mon 28a. Place 28a. Date (Mon 28a. D	Inpatient 2 ER/Outpatier of Injury th, Day Year) 28b. Time o Injury of Injury - At home, farm, str	Other: 4 Nursing Ho Sec. Injury at Work? M 1 Yes 2 No	me 5 A esidence 28d. Describe how inju- 28f. Location (Street a City or Town, Stat	ury occurred und Number or Rural Route Number, te)
s	Medical	(Check only one) 29 Medicel Exeminer: On the b and man 29b. Signature and title of certifier 30 Name and address of person who completed cads 31. Date filed (Month, Day, Year) 32. Page 19 Page		vestigation, in my opinion, death occurr	ed at the time, date ar	
Regis	trar	JUN 2 3 2006	and the ballions			

		•	For State Registrar	State	of Marylar		artment of H		d Mental	Hygie Reg.	40	06	19	853
	· ·		1. Decedent's Name (First, Middle,	Last)					2. Date Monti	of Death	Day	Year	3. Time of	Death
	Physicia /Medic		Bonnie K	aye	Foster	r .			June	13,	2 006	1001	6:50	A M
1	Examin		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town, or	r Location of D	eath		4c. County	of Death		
			Shady Grove Ad	ventist H	Hospita.	L	Rockvil				Montgo	omery	7	
	Funeral			5. Sex 1 □ M 2 🔏 F	7. Age (In yrs.		If Under 1 Year Months Days		Hrs. 8. Date (Mont June	of Birth h, Day, Ye	ear)	Cour	lace (State o	r Foreign
	Director		225-68-2172 Usual Residence of Decedent		57	Yrs.			June	13,	1949	Virg	ginia	
	and w	-	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					1	0d. Inside Ci	y Limits
	Mary f •hc	ō	Maryland Montg	omerv	Ga	itherst	ourg						1 🗆 Yes	2 XNo
	28s	Director	10e. Street and Number				10f. Zip Code			10g.	. Citizen of W	/hat Cour	ntry?	
	3a ol	<u>.</u>	415 Muddy Branch	n Rd., #1	104		2087	8		U	.S.A.			
	me 2	Funerai	11. Marital Status		edent Ever in U	l.S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes	or No-			an Indian,	
9	or the	Ē	1 ☐ Never Married 2X Marrie		2 🔀 No		1 ☐ Yes 2 No	Specify:	dello ricali, ell	··)	Specify	k, White,		
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23s or 28s-f ehow ha Medical Exeminer must be notified at	d by	3 Widowed 4 Divorced	Year or E			10 163 20110	opecity.			Specify	· Wh	ite	
5	72 h	Completed	15. Decedent's (Specify only highest		•	(Give	dent's Usual Occup kind of work done	during most of	working	16	b. Kind of Bu	siness/In	dustry	
12	within the state of the state o	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired ent Manago	•		Pr	operty	, Man	agar	
22	Hygie Hygie ther nt, II		17. Father's Name (First, Middle, L	ast)		Restat	ire manage		Name (First, M				agei	
au	o be	Be c	Joseph Durden	,					Marie			-,		
Maryland	Shoul od Me mari	ဥ	19a. Informant's Name/Relationship	p (Type, Print)		19b. Maili	ng Address (Street					State, Zip	Code)	
S	alth al 27 to r tree		James E. Foste	r (Husba	and)	415 M	Muddy Bra	nch Rd.	<i>,</i> #104	Gai	therst	urg,	MD 20	878
ē,	s 1 a of Hei item othe		20a. Method of Disposition		1 .	Place of Dispo	osition (Name of matory or other place	ce)	Date	200	c. Location -	City or To	own, State	
E	Page nent c int: If		14 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		State		L1 Cemete		/17/06	F1	int Hi	111,	VA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menlel Hygiene. important: if item 27 is marked other then "naturet", or iteme 23a or 28a-f show emportant: if item 27 is marked other then "naturet", or iteme 23a or 28a-f show any injury or other treumatic event, the Madical Examinal mail to notified at ODEs.		21. Signature of Juneral Service L	censed H	mera	22	Name and Address Turner-Re 1200 N.	obertsh				Roval	. VA 2	2630
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that	caused the dea	th. Do not en							Approximate Interval Bety)
	Physician		Immediate Cause (Final disease or condition		ardial I	Infarct	ion						Onset and E	eath
	/Medical		resulting in death)		(or as a consec		1011							
	Examiner		Sequentially list conditions,	b										
	ed sit	Examiner	Tany landing to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consec	meuce of								
	and and II-tran	хап	that initiated events resulting in death) Last	c	(or as a consec	suence of):				_				
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687	ficate physis the	edicai		d										
	eath certifi ettending for use as	N/	IF FEMALE: 23b. Was decedent pregnant		itcome of pregn		if				23d. Date	e of delive	nrv	
Box	death e ette	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Preg	birth 2 □ Feta nant at time of c		∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>	<u></u>			Mor		_	ear
o.	the the	hys	9 Unknown	9□ Unkr	nown									
Q.	res that igned by be deta	by P	Part II. Other significant condition	s contributing to d	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e.	Did tobac	co use contr	ibute to th	ne cause of d	eath?
ğ	w requires been sign should be	bed								1 Yes	2 💢 No	3 Prob	ably 4 □U	nknown
မ္မ	2 S T	Completed								Was an autopsy	24b. V	Vere auto	psy findings a	vailable
<u> </u>	T e se	Son							101	performed	d? d	eath?		
/ita	iician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?						Death (Check	only one)				
<u></u>	S S	ဥ	1 ☐ Yes 2 🖔 No			ER/Outpatier		4 🗆 Nursir	ng Home 5				v)	
ň	sing f	lon	27. Manner of Death 1 X Natural 5 ☐ Pending		nth, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ∐No	280. Desc	ribe now i	injury occurre	ed		
isi	Attending ir death. ector: After by the fune	icat	2 ☐ Accident investigated inve	ot be 200 Blac	e of Injury - At h	ome farm st	reet, factory, office	163 2 10	28f Locat	ion (Stree	at and Number	or Pura	l Route Numi	201
-	al or Attending Pt s after death. si Director: After th ad in by the funeral	Certification:	4 Homicide determin	build	ling, etc. (Speci	fy)	oot, tablery, office			or Town, S			, , , , , , , , , , , , , , , , , , , ,	, ,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying (Check only one)	xaminer: On the	e best of my knows of examination	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and p pinion, death o	lace, and due to occurred at the	the caus	e(s) and mar and place, a	nner as st and due to	ated. the cause(s)	
	To the within Comple	ž	29b. Signature and title of certifie	/	10		29c. Licens		~>		Date signed			
)	6		(Palse)			,	Da	26255	9	1	une 1	3/2	006	
1	7		30. Name and address of person w	DA C. I	se of death (Iter		DOC Print) Medica	. 1 -		7	· .	314	N/	
U	/		Patsy M 31. Date filed (Month, Day, Year)		Registrar's Sign	9901	INCONCO	XI CE	en ter	Dr	Kodav	rlle,	M D 20	1050
	Sta Registr		JUN 2 3 2		aras k	ature	a die			,				
	8 3 B.O.	<u> </u>	JUNGOL	000		10 10	St. Company							

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🗎 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June 7, 2006 10:50 p Nellie Firebaugh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 1 ☐ M 2 ☑ F June 15, 87 1918 Virginia Director 229-24-3644 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County s marked other than "natural", or Items 23s or 28s-f show numbic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No St. Mary's Mechanicsville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 39540 Hiawatha Circle 20659 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ٥ 3X Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filk timent of Health and Mental Hy tant: if item 27 is marked oth jury or other traumatic event To Be Eleanora Jane Armstrong James William Gillette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 39540 Hiawatha Circle Mechanicsville, MD Firebaugh/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sig lature of Funeral Service ROTTO L.1 S. Wat State Anatomy Board 655 W. Baltimore Street Birector un Baltimore, MD 21201 23a. Patr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Unknown Immediate Cause (Final disease or condition resulting in death) ances ₹rc Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physiclan/Medical the as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 C Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð pe 4 Onknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy performe 1 Tyes 2 Z No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 No 3 DOA 2 1 🗌 Yes his funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06 1000622 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) ures 31. Date filed (Month, Day, Year) 32 Registrar's Signature. State JUN 2 3 2006 DANE Registrar

		Please	State of Marylan	d / Depa	artme		ealth and l	Mental Hy		2006	19855
Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last Osra E. 4a. Facility Name (If not institution, give 402 Hornel St	Forbes street and number)			y, Town, or alti	Location of Deat	2. Date of Dea Month June	19		3. Time of Death
Funeral Director		5. Social Security Number 6. Se				er 1 Year	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Da March	16,	1924 Jan	lace (State or Foreign http:// naica WI
e Maryland Sa-f ahow	Director	10a. State 10b. County MD		y, Town or Lo Balti		e					0d. Inside City Limits 1 ☐ Yes 2 ☐ No
with th	I Dire	10e. Street and Number 402 Hornel St	reet			(ip Code 2122	4		10g. Ci	tizen of What Cour A	itry?
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or Itams 23e or 28e-f ahow event, the Medical Evertinar met be muffled at	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Dec If Yes, sp	edent of Hi ecify Cuba		Specify Yes or No to Rican, etc.)	r	14. Race - Americ Black, White, Specify: Bla	etc.
Z I Z I D-UUSO d within 72 hours af glene. er than "natural", or the Medical Evern	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give Seam	dent's Us kind of v DO NOT ISTE	ual Occupa vork done d use retired, ess	tion uring most of wo	rking		othing	dustry
naryland Z 2 should be filed 1 and Mental Hygir 1s marked other reumatic event, Il	To Be C	17. Father's Name (First, Middle, Last) John Forbes					Carol	me <i>(First, Middle,</i>	rra	У	
Mar nd 2 sho lith and 27 is m		19a. Informant's Name/Relationship (7) Chloe Forbes Sc			3			ural Route Numbe Baltir		or Town, State, Zip e MD 21	Code) 224
Balkimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: if them 27 is marked any injury or other treumstice.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Disponent cemetery, cre NION	osition (N	ame of		Date 1/06	20c. L	ocation - City or To	
Dalt permit. Departr Imports any inju		21. Signature of Funeral Service Licens	1 Annal							ve. Balt Essex	
Physician // Medical Examiner sthe buriat-transit	Ical Examiner	23a. Part1. Enter the disease, or comphock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		CONG juence of): 976/ juence of):	ESTIL	IE A		AILURE			Approximate Interval Between Onset and Death
death certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ŪNo 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	if death 3[⊒Ectopic ⊒ Other (pregnancy (specify)				23d. Date of delive Month	ery Day Year
	by	Part II. Other significant conditions of	ntributing to death but not res	sulting in the u	underlying	g cause give	en in Part f.	23e. Did t		use contribute to the	ne cause of death? bebly 4 Unknown
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r Vital Pysician: The is certificate director, peg	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3⊡ l	DOA Cthe		ath (Check only o		6 □Other (Specif	(v)
On O	atlon: T	27. Mannef of Death 1 Livinatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. fnjury Work	at	28d. Describe			
DIVISION To the Hospital or Attanwithin 24 hours after deatl To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	treet, fact	ory, office		28f. Location (: City or Tox		nd Number or Rura e)	d Route Number,
Hospi 24 hour Funer	edical	29a. Certifier 1 V Certifying Phr (Check only one) 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deal ation and/or in	th occurrenvestigati	ed at the tim on, in my op	e, date and place pinion, death occ	e, and due to the urred at the time,	cause(s date an	s) and manner as s od place, and due to	tated. the cause(s)
To the within. To the comple	Med	29b. Signature and title of certifier				29c. License				ate signed (Month,	
3		30. Name and a toress of person who of CNERGARA - S	completed cause of death (Item OARES 994	n 23a) (Type O FRA	Print)	N SG	HARE D	R. BAL	ETIM	ORE, M	21236
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Tegistrar's Sign	13 14	134	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** BM 06 11:50 20 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MORPITAL SAMARITAN If Under 24 Hrs. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number ce (State or Foreign Funeral Months Days Hours Carolina 1 □ M 2 X F North Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow traumatic event, the Medical Exeminer must be notified at 1'X Yes 2 □ No Directo Maryland MORR 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 212 items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "neturel", or 1 ☐ Yes 2 X No Specify: Š 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. 90 NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. Coltege (1-4or 5+) O 18. Mother's Name (First, Middle, Maiden Surname, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othen my injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) Be ၉ 19a. Informant's Name/Relationship (Typ), Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) etora 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2006 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Ad ss of Facility Home, P.A. eray. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart lawere. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic **Physician** (ancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inhibidiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of Examine use as the burial-transit Due to (or as a consequence of) ding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Frobably 4 ☐ Unknown 1 Tyes 2 No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? this certificate 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Matural 5 Pending

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

After the death. nerel Director: A filled in by the fu

within 24 hours a To the Funerel C

29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature land title of certifier P-1394 06/21 ransom M.D. 2006

1 Tes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE, MD-21239

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 2 3 2006

investigation 6 Could not be determined

2 Accident

4 Homicide

3 Suicide

JAIDEER

5601 MINGO RANI LOCH RAVEN BIVD., \$2. Registrar's Signature

nd address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 19857 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Grace Viola Garrett 2:05 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LongView Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year 1 May 21, 1911 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2ĬF Months Days Hours Min. 212-62-3372 95 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2871 Hilltop Drive 21102 U.S.A. Items 23e Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 T Never Married 2 T Married Baltimore, Maryland 21215-0036 ō 1 Yes 20 No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced 'netural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Allen Hann Estella G. Fridinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trainone. David H. Stepp - friend 2883 Hilltop Dr. Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) New Lutheran Cem. June 24,2006 Manchester, Md. 21. Signature of Funeral Service Licens 23. Narrad Adress of Facility Chapel P.A. 5296 Charmil Dr. Manchester, Md. 21102 Hard 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. detached à Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ funeral director, page 2 should be 2 1 No 3 Probably 4 □Unknown 1 TYes Be Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 A No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 44 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier d cause of death (Item 23a) (Type, Print) d address of person who complete Poole 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 🔒 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** Harriet Gossman 2006 June 6, 10:15 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 809 Brunswick Road #2N Baltimore Essex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 26, 193 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 73 Director 214-30-3205 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Evaminer must be notified at 1 ☐ Yes 2√2 No Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 809 Brunswixk Road #2N 21221 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 0 patient care health permit. Pages 1 and 2 should be file Osparfment of Health and Mental Hy Important: If Item 27 is marked oth eny injury or other traumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Lugenbeel Mary Manly 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Gossman/daughter in law 2137 Harkins Road Pylesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ∑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Sign ture of Funeral Service Licensee Ronald S. W. mector erra 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myocardual /Medical Due to (or as a consequence of) Examiner monar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Embolus has autopsy performed? certificate hermalor 1 ☐ Yes 2 **□** M5 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Fesidence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1. Naturaf 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month) Day, Year) 29c. License number 29b. Signatur title of ce ifier ٥ tonslid 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jamshid Mian, 9114 Phila delphia Rd, Site 108, Baltimore, MD 2123/ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Year Physician GIRSHMAN ZOCL Jun-c /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE N/A LEVINDALE HEBREW HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month Day, Year) 09/10/1929 9. Birthplace (State or Foreign Country) UKRAINE 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F 76 213-41-3696 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itams 23e or 28a-f ahow It e Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No BALTIMORE MD BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16 OLD COURT ROAD #514 21208 U.S.A. filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. WHITE 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DENTIST DENTISTRY permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If itam 27 Ia marked othe eny injury or other traumatic evant. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNOBTAINABLE KHUSID FANIA ISRAEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 OLD COURT ROAD #514 - BALTIMORE, MD 21208 LEV GIRSHMAN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 06/22/2006 OWINGS MILLS, MD HAR SINAI CONG. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician VAscular /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Icissase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 L No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 TYAS 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attanding in 24 hours after death. 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М after death the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours a To the Funarel E Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier erson whe completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State JUN 2 3 2006 Registrar

			1 - For State Registrar		epartment of Health and M Certificate of Death	Mental Hygier	2000 13000
ē.	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) BETTY J. GRIER 4a. Facility Name (If not institution, give s	street and number)	4b, City, Town, or Location of Death	2. Date of Death Month JUR	Day Year 3. Time of Death 3. County of Death 3. Time of Death 3. Time of Death
	Funeral Director		5. Social Security Number 6. Sec 216-34-6534 1C Usual Residence of Decedent	M 2□ F	s. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	1937 NC
	th the Marylar or 28a-f ehow	Director	10a. State 10b. County MD N/A 10e. Street and Number	BALTIMO	ORE	10g.	10d. Inside City Limits 1 ☐ Yes 2 ☐ No X Citizen of What Country?
9003	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Department of Heelih and Mental Hyglene. Important: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow important: If Item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow appray hjury or other traumatic event, I're Medical Examinar must be nutilised at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give() Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	S.A. 14. Race - American Indian, Black, White, etc. Specify: BLACK
and 21215-0036	I be filed within 72 that I Hygiene. od other than "nate event, I'm Medic	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 10th 17. Father's Name (First, Middle, Last)	completed) (9 College (1-4or 5+)		ne (First, Middle, Maid	
re, Maryland	is 1 and 2 should be Heelth and Mental tem 27 le marked other traumatic eve		TOHN WILLIAM 19a. Informant's Name/Relationship (Ty, MARCINA PURNELL) 20a. Method of Disposition	DAUGHTER 310	Mailing Address (Street and Number or Aut OPE.PRESTON ST. ED Disposition (Name of	BALTO. ME	
Baltimore,	permit. Pages Department of Importent: If It eny Injury or o		1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21 Ignature of Funeral Service License	emoval from State MD. NA	crematory or other place) T'L MEM. PK. JUNE CALAVERY Address of RUGGS 1412E. PRESTON S	FUNERAL	HOME
8760,	Crate be executed Medical Examiner Supering transit	Ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	it enter the mode of dying, such as cardiac): SHRUCTIVE PULMO,):	or respiratory arrest,	Approximate Interval Between Onset and Death
Box 6	that the death certifice ed by the attending pr detached for use as ti	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	law requires as been sign 2 should be	Completed by Ph	Part II. Other significant conditions cor	stributing to death but not resulting in t	he underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital Records,	To the Hospitel or Attending Physician: The inwithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	To Be	27. Manner of Death	ospital: 1 npatient 2 ER/Outp 28a. Date of Injury (Month, Day Year)	atient 3 DOA Other: 4 Nursing Ho	1 ☐ Yes 2 ☐ 1 h Check onli one	No 1 Yes 2 No 6 Other (Specify)
Division	el or Attendir s after death. al Director: Af ed in by the fur	Certification:	1	28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
)	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	ician: To the best of my knowledge, ner: On the basis of examination and/ and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur 29c. License number	red at the time, date a	and place, and due to the cause(s) Date signed (Month, Day, Year)
	Sta Registr		30. Name an oddress of person who con Balwakshma 31. Date filed (Month, Day, Year) JUN 2 3 200	nan M.D. G.	99573 Maryand G	reneral	Hospital

		-	For State Registrar	State of Marylar		nent of Health cate of Deat		rgiene 006	19861
	· ·		1. Decedent's Name (First, Middle, Las	it)			2. Date of De	aath Day Year	3. Time of Death
	Physici: /Medic		Elizabeth Harri	day			June	16,2006	Swa M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	1-La / 7	. City, Town, or Location	n of Death	4c. County of Deat	h
			Makyluna Ge	ex 7. Age (in yrs.	last histogram	Under 1 Year If Under	er 24 Hrs. 8. Date of Bi	dh O Bid	halana (Stata as Faraiga
	Funeral		5. Social Security Number 6. So	ox 7. Age (my/s. 91		onths Days Hours	Min. (Month, D.		hplace (State or Foreign untry)
	Director	-	217-38-0416 Usual Residence of Decedent	91			Feb 5,	1915	
	/land		10a. State 10b. County	10c. Ci	ty, Town or Location	on			10d. Inside City Limits
	Man 1-1 sh	to	MD	1	Baltimore	2			1√2 Yes 2 □ No
	h the	Director	10e. Street and Number		1	Of. Zip Code		10g. Citizen of What Co	untry?
	4 within 72 hours after death with the Maryland jiene. r then "naturel", or tieme 23a or 28e-1 show the Madical Examiner must be nutified at	aiD	1000 N. Gilmore S	treet		21217		USA	
)	eme eme	Funerail	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was	Decedent of Hispanic C s, specify Cuban, Mexic	Origin? (Specify Yes or North, Puerto Rican, etc.)	0- 14. Race - Ame Black, Whit	
98	or it	y F.	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give	j	Yes 2∭ No Specif		Specify: b1	ack
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Maryland	Should No.		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing A	ddress (Street and Num	ber or Rural Route Numb	per, City or Town, State, 2	Zip Code)
	and 2 : eaith ar n 27 is		MD General Hospit	:al	827 Lir	iden Avenue	Baltimore.	MD 21202	
Je,	一工るさ		20a. Method of Disposition	1 1	Place of Dispositio	n (Name of	Date	20c. Location - City or	Town, State
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Baltimore,	permit. Page Depertment Important: Il any injury o		21. Signature of Fuseral Service Licen	isee	22. Na	me and Address of Fac	Poord 655 to	7 Poltimoro	Stroot
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8760,	Physician // Medical Examiner and physician	ai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Coquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiliated events resulting in death) Last	Due to (or as a consect of the conse	quence of):	K			Interval Between Onset and Death
P.O. Box 6	The law requires that the death certificate be executed ate hes been signed by the ettending physiclen and page 2 should be deteched for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1	al death 3 □Ect death 5 □ Ott	opic pregnancy ner (<i>specify</i>) lying cause given in Pai	n I. 23e. Did	23d. Date of del Month tobacco use contribute to	Day Year
ğ	w require been sig should b	8		·· -			10	Yes 2 No 3 Pr	obably 4 Unknown
Records,	The law requite hes been age 2 should	Completed					24a. Waa auto perf 1 □ Yes		utopsy findings available completion of cause of
Vital	ysician: The is certificate he director, page	0	25. Was case referred to medical			26. Pla	ace of Death (Check only		
f V	Physician: this certificatal director, particular	To B	examiner?	Hospital: 1 Impatient 2	ER/Outpatient	B DOA Other: 4	Nursing Home 5 ☐ Res	idence 6 Other (Spe	cify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	i
. <u>Ö</u>	Attending r death. ector: After by the funer	atic	2 ☐ Accident investigation			M 1 ☐ Yes 2			
Division	or Attendate death	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		factory, office	28f. Location City or To	(Street and Number or Ru own, State)	ıral Route Number,
	urs el urs el ural D			<u> </u>					
	To the Hospitel or Attent within 24 hours effer deall To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	sysician: To the best of my kn niner: On the basis of examinand manner stated.	owiedge, death oc ation and/or invest	curred at the time, date igation, in my opinion, d	and place, and due to the leath occurred at the time	e cause(s) and manner as , date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and marrier stated.		29c. License numbe	er -	29d. Date signed (Mont	h, Day, Year)
	E ¥ E 8		1 Tale 2	mo		90 F	7/2	6/16/06	
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type Prin	076		1.5	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
			31. Date filed (Month, Day, Year)	22. Registrar's Sign	111.0,9	o Mary.	land Gier	repal Ho	spital
	Regist	ate rar	JUN 2 3 2005	Same A	Sparke	1			

DHMH 17 Rev 1/2001

06-04301 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Steven Herzog 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ June 20, 2006 0310 hrs STEVEN FRANCIS **Medical Examiner** HERZOG 4c. County of Death n/a 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Union Memorial Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Country) MD Hours Months Davs Director 53 JUNE 28.1952 216583489 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No MD HARFORD JOPPA 23a or 28a-f show notified at once. 28a-f show hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 578 TRIMBLE ROAD LOT 21085 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X No Yes WHITE Yes 2 X No specify: Specify: 4 X Divorced If Yes, Give Year 3 Widowed ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Inner of Health and Mental Hygiene.
ant: If item 27 is marked other than "r Baltimore, MD 21215-0036 PLUMBING 12 PIPE FITTER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) HARRY A. HERZOG JR. Be FRANCES L. McNAMARA 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ DAWN M. SHAW DAUGHTER 578 TRIMBLE ROAD JOPPA, 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State METRO CREMATORY 6/23/06 BALTIMORE, MD permit. Pages Department of Important: 1 Donation 5 Other Specify 0 21. Signature of Funeral Service Licen 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTO, MD 21237 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** 23a, Part I. Enter Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? Yes 2 N Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Otherexaminer? Hospital: After this o Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 ٩ 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Yea 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Division 1 Yes 2 No Pending To the Funeral Director: completely filled in by the f Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 21, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registra

32. Registrar's Signature

			1 - For State Registrar	State of Maryla		artment			nd Me	ental H	ygiei Reg.	4000		863
100	Physici /Medic		1. Decedent's Name (First, Middle, Last) Letha E. I	Harris						2. Date of D Month June		2006 Year		e of Death
	Examin		4a. Facility Name (If not institution, give str 115 Judywood Lai	ne		Es	sex					4c. County of Dea Baltim		
34	Funeral Director		5. Social Security Number 218-26-8914 6. Sex Usual Residence of Decedent		s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of E (Month, L Nov.	18,	9. Bir	thplace (Standary) W\	ate or Foreign 7A
	Maryland	tor	10a. State 10b. County MD Baltimon		City, Town or Lo									e City Limits Yes 2. No
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 115 Judywood La	ine		10f. Zip	Code 212	21				Citizen of What C	ountry?	
980	be tied within 72 hours after death with the Maryland Hygiene. Hygiene do ther than "netural", or items 23a or 28a-f show event, the Madical Expriner roust be notified at	by	11. Marital Status 12 1 Never Married 2 Married **Widowed 4 Divorced	. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Deced If Yes, spec			in? (Spec Puerto R	ify Yes or Nican, etc.)	lo-	14. Race - Am Black, Whi Specify: W	te, etc.	٦,
Maryland 21215-0036	e filed within 72 ha al Hygiene. I other than "netu vent, the Madical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 6th	tion completed) College (1-4or 5+)	(Give	dent's Usua kind of won DO NOT us DMEMA	k done di e retired)	tion uring most (of working	9		Kind of Business	/Industry	
yland	should be fited and Mental Hygis I marked other I matic event, it	To Be (17. Father's Name (First, Middle, Last) Howard Warner					Ivy I	Lema	Jiv	ide			
	and 2 sh lealth and m 27 is m har traum		Janet Noel / dau	ighter	420	Mira	ble		e Ba	ltim	ore	y or Town, State, MD 212	24	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marks eny injury or other traumatic once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Place of Dispo cemetery, cren lorelar	natory or other Me	mor:	ial 6				Location - City or Baltimo:		
Bal	Departition Departition Strategies on Strategies December 2000 Strategies on Strategie		21. Signature of Funeral Service Licensee	Conne	lly	2. Name and	ellv	Fun	era.	l Hon	ie d	Ave. Ba of Esse		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tiens that caused the decause on each line. Alzhe Due to (or as a conse	mer) []		ent ent	•	respiratory	arrest,			mate Between and Death
3760,	ate be executed nysicien and he burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conse										
P.O. Box 6	ath certiff attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 1 No 9 □ Unknown	. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pre Other (spe			argana .			23d. Date of de Month	ivery Day	Year
rds, P	w requires that the de been signed by the a should be detached	by	Part II. Other significant conditions control (buting to death but not re								o use contribute to 2 □ No 3 1 Pr		of death?
	: The law re cete has bee : page 2 sho	Completed		ellirus					_	24a. Wa autr per 1 ☐ Yes	opsy formed?	death?	completion	ngs available of cause of
Z:	Physician: r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 D No	spital:	☐ ER/Outpatien	t 3 DO	Other			Check only		6 □Other (Spe	-4.5	
on of	iding Phy th. : After this funeral o		27. Manner of Death 16 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury Work?		28			jury occurred	ciry)	
Divisi	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter his certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre city)	eet, factory,	office		28	f. Location City or To	(Street own, Sta	and Number or Ri ate)	ıral Route N	lumber,
	he Haspii n 24 hour he Funeri pletely filli	edical	29a. Certifier (Check only one) Ly Certifying Physic 2 Medical Examine	ian: To the best of my ki r: On the basis of examinand manner stated.	nowledge, death hation and/or inv	occurred a restigation,	it the time in my opi	e, date and nion, death	place, an occurred	d due to the at the time	cause , date a	(s) and manner as nd place, and due	stated. to the caus	se(s)
)	To the complete of the complet	Σ	29b. Signature and title of certifies	Illine	M		License		41		29d. [Date signed (Mont	Day, Yea	006
	4		30. Name and address of person who com	cilbrem	D 10	7 B	eac	onR	oad	Ba	الم	nore	mD.	31220
	Sta Registr		31. Date filed (Month Pay Year) 2006	32 Registrar's Sign	Takere A									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 35 PM **Physician** Hoopert TUNC /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) N/A Baltimore Union Memorial Hospital f Under 1 Year | If Under 24 Hrs. | Ionths Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 78 Yrs. 216-24-9114 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 **USA** 7875 St. Gregory Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Heelth and Mental is marked Anna Bowersox William D. Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Heelth a 7875 St. Gregory Drive, Dundalk, Md. 21222 Russell Hoopert Husband Depertment of Heelth Important: If Item 27 eny Injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) June 22, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State Bayview Crematory 2006 Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Phrt1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Inset and Deat Bradycardi Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physicien and s the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Nonknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 20 No 1 Yes After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient Certification: To 1 Depatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death investigation 2 Accident within 24 hours after death To the Funeral Director: . completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union MARITA MIKE 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State Registrar JUN 2 3 2006

Kenneth Leon Hanlin

Please Type or Print in Black Indelible Ink

Maryland / Department of Health and Mental Hygiene

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eilleti Leon Han	1- For State Certificate of L	Death R	eg. No. 2006 198
Physician Medical Examine		2. Date of Dea Month June 18, 2	
	4a. Facility Name (if not institution, give street and number) 1100 Frederick Street	City, Town, or Location of Death Hagerstown	4c. County of Death Washington
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs last birthday)		rth(MM/DD/YYYY) 9. Birthplace (State or
Director	233-34-5653 ₁ X _{M 2} 80 _{Yrs}	Months Days Hours Min. April	4, 1926 Wee Saty) Virginia
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Maryland 28a-f show any d at once.	Maryland Washington Hagerstown		1 X Yes 2 No
the Maryland as or 28a-f she	10e. Street and Number 1158 Luther Drive	Of. Zip Code 1 21740	0g Citizen of What Country? U.S.A.
be filed within 72 hours after death with the Maryland mall Hygiens had coher than "natural", or items 23a or 28a-f she cent, the Medical Examiner must be notified at once De Computed by Ennoral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Specify Yes or No	- 14. Race - American Indian, Black,
or items 23	1 X Never Married 2 Married Armed Forces? If Yes 1 No.	specify Cuban, Mexican, Puerto Rican, etc.) $ = 2 X \text{ No } \text{ specify:} $	White, etc. Specify: White
hours after "natural", Examiner	or Dates: 1940	Usual Occupation (Give kind of work done	Specify Wnite 16b. Kind of Business/Industry
5-0036 ed within 72 hour tygrene. other than "natu	Elementary/Secondary (0-12) College (1-4 or 5+) 4 Seni	or Engineer	N.A.S.A.
5-0036 led within 72 Hygiene. other than '	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, I	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Thomas G. Hanlin	Edna Hester S	
O a a a a f		ddress (Street and Number or Rural Route Nur afalgar Dr., Hagerstow	
re, N s 1 and f Health f item er trau	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or othe		20c. Location - City or Town, State
Baltimore, permit. Pages l ar Department of Hee Important: If ite	4 Donation 5 Other Specify: Sites Ceme		Dorcas, WV
Baltimore, ML permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum:	21 James re of Funeral Servic Liousee 22 Na 22 Na 23 Na 11	neand Address of Facility Naeffer's Funeral Home N. Main St., Petersbu	rg, WV 26847
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure List only one cause on each line.		Pest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherose Due to (or as a consequence of):	lerotic Cardiovascular	- Di sease Death
3	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
ted nisit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
ecuted and transit	I u		
760, icate be executed physician and the burial - transit	AMENDED Item #23a&27 Pe IF FEMALE: 23c. If yes, outcome of pregnancy	r ME G857 7/19/06 JH	23d Date of delivery
Sox 6876 leath certificate e attending phy for use as the		death 3 Ectopic pregnancy	Month Day Year
by the attending sched for use as t	1 Yes 2 No 9 Unknown 9 Unknown	r (Specify)	
ires that the signed by I be detach			obacco use contribute to the cause of death? s 2 No 3 Probably 4 ✔ Unknown
Records, The law requires ficate has been sig		24a. Was	an 24b. Were autopsy findings available
ecor he law i nte has l		autop perfo 1 ✓ Yes	rmed? death?
ital Recician: The sector, page	25. Was case referred to medical	26.Place of Death (Check only one)	
of Vit	1 Yes 2 No 1 Inpatient 2 ER/Outpatient		Residence 6 Other: Scene
ISION Of Attending Ph or death rector: After t by the funeral	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	1 Yes 2 No	, ,
.≥ <u>5 ₹ 5 5 </u>	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	factory, office building, etc. 28f, Location (Sor Town, S	Street and Number or Rural Route Number, City State)
Diverse to the Hospital of within 24 hours at To the Funeral Decompletely filled		d at the time, date and place, and due to the caus	se(s) and manner as started
To the Hos within 24 h To the Fur completely	one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred at the time, date	
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) June 19, 2006
ox I	30. Name and address of person who completed cause of death (Item 23a)		
	Ana Rubio MD. Assistant Medical Examiner 111 Penn St	eet, Baltimore, MD 21201	
Star Registra	e 31. Date filed (Month, Day, Year) 32. Regis ar's Signature JUN 2 3 2006	arke	
DHMH 17 Rev 1/200			

nita Emmy Hein	State of Maryland /	pe or Print in Bia Department of He Certificate of De	alth and Mental Hy		2006	1006
Physician/ Medical Examine	Registrar 1. Decedent's Name (First, Middle,Last) ANITA EMMY HEIN			Reg. No. 2. Date of Death Month Day June 21, 2006	Year 040	e of Death 07 hrs
<i>*</i>	Facility Name (if not institution, give street and number) 2066 Lark Hall Road	Du	y, Town, or Location of Death ndalk	Ε	c. County of Death Baltimore County	
Funeral Director	212-42-0327 1 M 2XF		Inder 1 Year If Under 24Hrs. Inths Days Hours Min.	Aug. 6, 194	(DD/YYYY) 9. Birthplace 10 Foreign Ger Country)	
Maryland 28a-f show any 1 at once.	MD Harford	Oc. City, Town or Location Joppa				rside City Limits Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once		10f.	Zip Code 21085	10g. Citi	zen of What Country?	
s after death wi iral", or items inner must be by Funers	3 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes, sp 1 Yes	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 X No specify: ual Occupation (Give kind of w.	Rican, etc.)	14. Race - American Indi White, etc. Whi Specify: Kind of Business/Industry	
5-0036 led within 72 hour led within 72 hour dygiene. other than "natu the Medical Exa	Elementary/Secondary (0-12) College (1-4 or 54	during most of	working life. DO NOT use retir	Mu.	hlys Baker	. А
21215-0036 uld be filed within 77 Mental Hygiene. marked other than evernt, the Medical	Bernhart Dietz	19h Mailing Add		(First, Middle, Maiden Koler		do
10re, MD 21 ages 1 and 2 should nt of Health and Me It: If item 27 is ma other traumaric ev	Warren James Hein-spous 20a. Method of Disposition		layton Road-	Joppa, Ma	ryland 210	085
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 2 Signature of Funeral Service Ligensee	Memorial Ga	and Address of Eacility		imonium,Mary	21224
Physician	23a. Part I. Enter the disease, or complications that caused the	8800	Harford Ro		ock, or heart Appro	and
/Medical §xaminer	Sequentially list conditions,	quence of): serosclerotic Cardiovas	cular Disease		Betw	een Onset and Death
executed an and al-transit		quence of):				
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical E)	UNPENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown AMENDED 23c. If yes, outcome 1 Live birth 4 Pregnant at ti 9 Unknown	2 Fetal de			d. Date of delivery Month Day	Year
P.O. es that the igned by oe detach		but not resulting in the under	ring cause given in Part I.	23e. Did tobacco 1 Yes 2 24a. Was an autopsy performed?	No 3 Probably 4 24b. Were autopsy fin prior to completio death?	Unknown
of Vital Recing Physician: The After this certificate Uneral director, page uneral director, page on: To Be Con	25. Was case referred to medical examiner?	, , , , , , , , , , , , , , , , , , ,	26 Place of Death (Check of			2 No
Division of Vital Records, pital or Attending Physician: The law requirours after death. Beral Director: After this certificate has been stilled in by the funeral director, page 2 should the contribution. To Re Committee	1 Ves 2 No Inpatien 27 Manner of Death 28a Date of Injury	28b. Time of Injury		1 Home 5 Reside	ance 6 🗸 Other: Scene ary accurred	
Division o Spital or Attending tours after death, neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	iry - At home, farm, street, fac	ory, office building, etc.	28f. Location (Street a or Town, State)	nd Number or Rural Route	e Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Z9a Centiler		my opinion, death occurred at	the time, date and pla	ice, and due to the cause(
	29b. Signature and title of certifier		29c. License number O.C.M.E.		Date signed (Month, Day, e 21, 2006	Year)
10	30. Name and address of person who completed cause of de Ana Rubio MD. Assistant Medical Exami	ner 111 Penn Stree	t, Baltimore, MD 21201			
Stat Registra	JUN 2 3 2006 Step	nes It Apar	W			
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				State of Maryland / Departs 1 - For Registrar Certif	ment of Health and M	ental Hygier	2006	19867
					icate of Death	2. Date of Death	lo:- 0 0	2 Time of Dooth
		Physici	an	1. Decedent's Name (First, Middle, Last)		Month D	ay Year	3. Time of Death
		/Medic		Janet Hughes	Oit. Town and applies of Dooth		1006 Ic. County of Death	7:30 AM M
	4	Examin	er		D. City, Town, or Location of Death			
					Havre de Grace TUnder 1 Year If Under 24 Hrs.		Harford	lace (State or Foreign
	Н	Funeral Director		188-24-7308 1□ M 2♥ F 78 Yrs. M	onths Days Hours Min.	8. Date of Birth (Month, Day, Yea June 10,		lace (State or Foreign try) unk
				Usual Residence of Decedent		Julie 10,	1921	
		yland		10a. State 10b. County 10c. City, Town or Locati			10	0d. Inside City Limits
		e-f s	ç	MD Harford Havre	de Grace			1 ☐ Yes 2√2 No
		permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other traumatic event, It. Medical Examinat must be notified at ORGS.	Director	10e. Street and Number 415 S. Market Street	10f. Zip Code 21078	10g. (Citizen of What Coun USA	try?
		leath ns 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - America	
	10	r then	표	1 Never Married 2 Married 1 ☐ Yes 2 🕅 No		Rican, etc.)	Black, White,	
	93	urs a	Ď	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	Yes 2♥ No Specify:		Specify: whi	te
~	5-0	72 ho	Completed	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kind	t's Usual Occupation d of work done during most of workii NOT use retired)	unk 16b.	Kind of Business/Inc	lustry unk
AM	121	vithin ne. han *	mpl	Elementary/Secondary (0-12) College (1-40r 5+)	NOT use retired)			
0	2	iled v tygie ther t	ပိ	unk unk 17. Father's Name (First, Middle, Last)	unk 18. Mother's Name	/First Middle Maids	an Sumame)	unk
30	Maryland 21215-0036	12 should be filed within hand Mental Hygiene. 7 is marked other than "r traumatic event, the Med	To Be	Tr. Failer 3 Harris (1 //3), Micciol, Easty	dire to money than	(Not, Made)	on comanic,	
1	ar _y	shoul nd Mo mari	F		ddress (Street and Number or Rura			
1		nd 2 alth a 27 is		Harford Memorial Hospital 501 S.	. Union Avenue Ha	ivre de Gr	ace, MD	21078
	ē,	s 1 a if Hez item othe		20a. Method of Disposition 20b. Place of Disposition cemetary, crematory, cre	on (Name of Dory or other place)	ate 20c.	Location - City or To	wn, State
	Ë	Page nent o nt: If		1 □ Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 ☑ Other (Specify) in state				
	Baltimore,	permit. Departmine importe any injuite.			ame and Address of Facility te Anatomy Board	655 W. Ba	ltimore S	treet
	<u>—</u>	205 2 2		Ball Ball	timore, MD 2120			
				23a. Part1.\Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	he mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition & E. Coli backer	-emia			Onset and Death
2	1	/Medical Examiner		resulting in death) Due to (or as a consequence of):	inonia			
8		Califfici	_	Sequentially list conditions, b. E. calc pre	inone			
2		ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Little Uniderlying Cause (Disease or injury that initiated events	,			-
10		be execut ician and burial-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			_	
. 1	09/	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	calE					
	687	ficate p phys		d				
	XO	certifical nding phy use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
+	ă	death a atte d for	cla	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Ot	topic pregnancy her (specify)		Month	Day Year
di	0	t the c by the ache	hys	9 Unknown				
رح	<u>ر</u> ر	requires that the	by P	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco	use contribute to th	
R	ğ	equire en sig				1 ☐ Yes	2 No 3 Proba	ably 4 Unknown
1	ecord	awre	Completed			24a. Was an autopsy	24b. Were autop	osy findings available
-	α	sicien: The lav certificate has rector, page 2	mo			performed	death?	
5	Vital	ian: rtifica stor, p	Bec	25. Was case referred to medical	26. Place of Death			
Ū	-	Physician: this certific ral director,	TO E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient :	3 ☐ DOA Other: 4 ☐ Nursing Hon	ne 5 Residence	6 □Other (Specify)
	, of	ding Phys h. After this funeral di		27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)		28d. Describe how in		
2	/ <u>ië</u>	Attending r death. ector: Afteby the fune	atle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
7	Division	r Att	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural ite)	Route Number,
	0	oital c urs af rel D iled ir		1				
		To the Hospital or Attending Physician: The lawinhin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death oc 2 ☐ Medical Examiner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, a tigation, in my opinion, death occurre	ind due to the cause ed at the time, date a	(s) and manner as stand due to	ated. the cause(s)
		o the ithin ; o the omple	Mec	29b. Signature and Ale of certifier	29c. License number	29d. D	ate signed (Month, L	Day, Year)
		⊢≯≓ŏ			HMCEDO	2 1	ne 2+4	2000/
	•			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	11 0033 ZZ	- V4		
				Vand Little DO SOI S. UNION	H005522	e De Gr	and P	40
		Sta	ite	31 Date filed (Month, Day, Year) 32 Registrar's Signature	3-			
		Regist		JUN 2 3 2006 15 100 100 100 100 100 100 100 100 100				

06-04219 **David Hutchins**

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	F	- For State Registrar		Certific	ate of L	Death			g. No.	UU	6 1986
Physicia Nedical Examin	-	Decedent's Name (First, Middle,Last) DAVID		HUTC	HINS			Date of Death Month June 18, 20	Day Y	ear	3. Time of Death 0619 hrs
		4a. Facility Name (if not institution, give	street and number)		4b	City, Town, or Loc			4c. Count	y of Death	
Funeral		Union Memorial Hospital 5. Social Security Number 6. Security Number	7. Age (Ir	n yrs. last bir			If Under 24Hrs.	8. Date of Birtl		YY) 9. Birth	place (State or
Director	2	219-82-6188 XX	M 2 F 45		Yrs.	Months Days	Hours Min.	07/04/	1960	Foreign Cou	ntry) Mary Land
any		Usual Residence of Decedent 10a. State 10b. County	100	City, Town	or Location						10d. Inside City Limits
Maryland 28a-f show any d at once,		Maryland N/A		Balti				·			1 XXYes 2 No
within 72 hours after death with the Maryland giene. rer than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once		10e. Street and Number 1100 North Charles	Street		ľ	Of, Zip Code 21218		10	g Citizen of V	What Count ISA	ry?
h with the ms 23a	_	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.		Decedent of Hispar , specify Cuban, M				ce - Americ	an Indian, Black,
ter deatl ", or ite	Funera	1XX Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X	(_{No}		es 2XX No s		,	Specify		White
5-0036 led within 72 hours after tygiene other than "natural", the Medical Examiner	ed by	15. Decedent's Education (Specify onl	or Dates: ly highest grade comple	ted) 16a.		Usual Occupation of working life. DO			16b. Kind of E	Business/In	dustry
36 thin 72 lee than "1	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		Unemp	oloyed			N	/A	
Hyge Hed		17. Father's Name (First, Middle, Last) Grover MacGregor H	utchins			18.	Mother's Name (F				
Me Me		19a. Informant's Name/Relationship (Ty	rpe, Print)			ddress (Street ar	nd Number or Run	ral Route Num	per, City or To	own, State,	Zıp Code)
MI nd 2 s alth a m 27		Grover M. Hutchins 20a. Method of Disposition	Fat			Charles		imore,	Md 212		own. State
Baltimore, permit Pages I an Department of He Important: If ite		1 Burial 2 XXCremation 3	Removal from State	crema	tory or othe			/06		-	Maryland
Baltimo permit Page: Department o Important:	Ì	4 Donation 5 Other Specify: 21. Annature of Funeral Annature Comments	see Nous	him		ne and Address of	Facility Mitch	hell-Wie	defeld F	uneral	Home Inc
Physician	+	23a. Part I. Enter the disease, or compl		death. Do n	ot enter the		York Road ch as cardiac or re				Approximate Interval
/Medical		failure. List only one cause on each immediate Cause (Final disease a.	Diabetic keto		is						Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as a consequ	ence of):							
	niner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of):							
xecuted 1 and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):							
ial ial	/Medical	X UNPENDED	AMENDED item	#2 3 a,27	,perÆ,	g856,6/26/0	06 TT				
Box 68760, e death certificate be the attending physic of for use as the but		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	of pregnancy		death 3	Ectopic pregnanc	СУ	23d Date Month		ay Year
Sox 687 leath certifi e attending for use as 1	sicia	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at tim 9 Unknown	e of death		r (Specify)			de T		
O. B. nat the d. d by the etached	by Physician	Part II. Other significant conditions		ut not resultin	ng in the uni	derlying cause give	en in Part I.				ne cause of death?
IS, P. quires then signe en signe del be de	ted b	ļ						1 Yes	and beginner		ppsy findings available
e law requir	Completed							autops perfori 1 V Yes 2	ned?		mpletion of cause of
tal Rec	S B B	25. Was case referred to medical examiner?					Death (Check on			1 0 103	2
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	의	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		Outpatient Time of Inju			Home 5 F	Residence 6 ow injury occu		
ion C tending eath tor: Af the fun	ation	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)			1 Yes	2 No				
Divis pital or At ours after d teral Direc filled in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home,	farm, street,	factory, office build	ding, etc. 2	8f. Location (S or Town, St		ber or Rura	al Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		Check only	an: To the best of my ki								
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner 29b. Signature and title of certifier	On the basis of examinant stated.	ation and/or	investigatio	n, in my opinion, de		the time, date a	and place, and 29d. Date sig		
	-	///	1			O.C.M.			June 19,		,
		30. Name and address of person who of Mary G. Ripple MD. Dep	completed cause of dear			Penn Street, E	Saltimore MC	21201			
St	ate		32. eqistrar's	Signature	A 111	& D	Janimore, ML	, _ 1201			
Regist		31. Date filed (Month, Day, Year) JUN 2 3 20	UD Block	, 1	1473	W. C.					

DHMH 17 Rev 1/2001

Registrar

3:59

WILLIAM JONES

		. 101	partment of Health and Ment ertificate of Death	-	ne 2006	1987
Physic /Med		1. Decedent's Name (First, Middle, Last) ALBERT JOSEPH JULIAN		ate of Death	2006 Year	3. Time of Death
Exami		4a. Fecility Name (If not institution, give street and number) 200 L Hazelnut Court	4b. City, Town, or Location of Death Bel Air		4c. County of Death Harford	
Funeral Director		5. Social Security Number 218-28-2660 6. Sex 1 X 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	ay) If Under 1 Year If Under 24 Hrs. 8. Days Hours Min. July	ate of Birth lonth, Bay Ye	1932 Mar	lace (State or Foreign yland
Maryland I-f ehow	tor	10a. State 10b. County 10c. City, Town or	Location 1 Air		1	0d. Inside City Limits 1 ☐ Yes 2X No
death with the Maryland ms 23a or 28a-f show	al Direc	10e. Street and Number 200 L Hazelnut Court	10f. Zip Code 21015	10g.	Citizen of What Cour	ntry?
036 ors after death with the Marylan set; or items 23a or 28a-1 ehow Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, □ Yes 2 X No Specify:	es or No- , etc.)	14. Race - Americ Black, White, Specify: Wh	
215-0 215-0 hin 72 ho in "natur	ompleted	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of working e. DO NOT use relired) ogram Director	Ba	Kind of Business/Ind Itimore epartment ecreation	City
₹ a la b s	To Be Co	17. Father's Name (First, Middle, Last) Joseph Julian	18. Mother's Name (First Elizabeth	t, Middle, Maid Varq	len Sumame) JO	
Mar Mar Md 2 sho lith and 27 is m		Antoinette Julian-spouse 200	ailing Address (Street and Number or Rural Rout L Hazelnut Court-I	Der VI	.I, Mary re	1110
Imor		1 XBurial 2 Cremation 3 Removal from State Morelan	sposition (Name of remaining to the place) ID Memorial Or Memorial		rkville,	
Baltim permit. Par Department Importent: eny fojury		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 8800 Harford Road	CHAP Parkv	EL10F,ME	MORJĘS 27234
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	enter the mode of dying, such as cardiac or respondence of the concentration of the concentra	_		Approximate Interval Between Onset and Death
8760, 8760, 2 and hysicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d				
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	Day Year
ords, I	à	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part !. 2	3e. Did tobacc	o use contribute to the	ne cause of death? ably 4 □Unknown
al Recc The law recate has be	Completed			4a. Was an autopsy performed ☐ Yes 2	prior to cor death?	psy findings available inpletion of cause of 2 No
Division of Vital Records, to Attanding Physician: The law requires tale death. Director: After this certificate has been signed in by the funeral director, page 2 should be to	itlon: To Be	25. Was case referred to medical examiner? 1	e of 28c. Injury at 28d. D	-		1)
DIVISI al or Attsr s after dea al Director	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Lc	ocation (Street ity or Town, St	and Number or Rura ate)	l Route Number,
he Hospit in 24 hour he Funera pletely filk	Medical (29a. Certifier (Check only one) **Certifying Physician: To the best of my knowledge, di 2 Medical Examiner: On the basis of examination and/o and manner stated.				
Tot	Σ	29b. Signature and title of certifier	29c. License number D18487	29d. I	Date signed (Month,	Day, Year)
6		30. Name and address of person who completed cause of death (Item 23a) (Type 10 THANT 60 2 S. AT Le	po, Print) (UT) RUAD,	BEL AI	R, MD.	21014
S: Regis	ate trar	31. Date filed (Month, Day, Year) 3 2006 32. Redistrar's Signature	positi			

	1	, .	For State Registrar	State of Mar	yland / Depa <i>Ce:</i>	artment of H <i>rtificate of l</i>	lealth and M D <i>eath</i>		giene Reg. No.	2006	19871
			Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		HENRY	JOH	noznh			JUNE	6	2006	(210 P M
	Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or	Location of Death		4c. C	county of Deat	h
			NORTHWEST	HOSPITAC			LLSTOWN		[3	ALT I MO	
	Funeral Director		5. Social Security Numbeunk 6. S	Gex 7. Age ((In yrs. last birthday) 68 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da) Jan 9	y, Year)	9. Birt Co	hplace (State or Foreign untry)
	pu ,	-	Usual Residence of Decedent		On City Town on L	anti					tod tasks on their
	Maryla I-f ehov	tor	MD 10b. County Carrol1	1	Oc. City, Town or Lo Sykes						10d. Inside City Limits
	r 28s	Funeral Director	10e. Street and Number			10f. Zip Code	····		10g. Citize	en of What Co	untry?
	th wit	a D	6655 Sykesville	Road			21784			USA	
	dea	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	ispanic Origin? (Spon. Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14	4. Race - Ame Black, White	
920	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Medical Exarcinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2)X No	Specify:				black
Ŏ	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occupa	ation	unk	16b. Kind	d of Business/	Industry unk
7121	within right	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	, ig			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at ODGs.	Be	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name	e (First, Middle,	Maiden S	iumame)	unk
lary	2 shoul t and Me is mart raumati	ဥ	19a. Informant's Name/Relationship (•		ng Address (Street					
	is 1 and of Heelth item 27 other to	1	Northwest Hospit 20a. Method of Disposition	•	20b. Place of Dispo	osition (Name of matory or other place	· · · · · · · · · · · · · · · · · · ·	ndallst Date	20c. Loca	M1) 21 ation - City or	133 Town, State
Baltimore,	it. Page intment c intent: if injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Special Service Lice) in state		2. Name and Addres					
Ba	Depa impo any		21. Signature of Funeral Service Lice Ronald S.	1/ dece	Ba	tate Anato Iltimore,	omy Board MD 2120	1		imore	Street
dili	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.				or respiratory ar	rest,		Approximate Interval Between Onset and Beath Menufes
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		ζ.				
H	_	-	Sequentially list conditions,	b. Due to lor as a	Dirafo	Preuno	mune				days
	ted rsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to for as as	onsequence on.	<i>V</i> .					U
•	xecu and	Examiner	that initiated events resulting in death) Last	C	consequence of):						
68760,	ficate be executed physician and s the burial-transit	edicai E		_ d							
_	artifica ling pl e as t		IF FEMALE:	wa _ 200022	(3)				-		
P.O. Box	Attending Physicien: The law requires that the death certif refath. refath. sctor: Atter this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	·		23	id. Date of deli Month	very Day Year
	ires that i signed by I be deta	þ	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.			e contribute to	the cause of death?
Š	v requ been should	eted									
Division of Vital Records,	Physicien: The lav this certificate has al director, page 2	Completed							an sy rmed? 2 XNo	death?	topsy findings available completion of cause of
Sit Si	icien sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		100	26. Place of Death	(Check only o	пе)		
of	Phys this al dir	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient			4 Nursing Ho				cify)
Ĕ	ling f	<u>0</u>	1XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time o	Worl		28d. Describe h	low injury	occurred	
<u>s</u>	death death tor: the f	cat	2 Accident investigation 3 Suicide 6 Could not be	OB Place of trium	- At home form et		Yes 2 □No	20f Location (6	Stroot and	Alumbas as Ou	ral Route Number,
<u>≥</u>	after Direct In by	Certification:	4 Homicide determined	building, etc.	r - At home, farm, sti (Specify)	eer, ractory, office		City or Tow	vn, State)	ivamber or Ru	rai Houte Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the best of eminer: On the basis of e	xamination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the ded at the time, d	cause(s) a	nd manner as lace, and due	stated. to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner state	u.	29c. License	number		∠9d. Date	signed (Month	n, Day, Year)
	F ≱ F 8			-1			005973			, , , , ,	
			30. Name and address of person who	completed cause of dea	th (Item 23a) (Type		00-1/3	~	The	ene 6	,0006
			DEBURAH WATSU	/ M.D.	MRTHWE	=0T HU.	SPITAL	5401	000	COSR	T ROAD
	Sta	te	31. Date filed (Month, Day, Year) JUN 2 3 200	32. Registrar's	s Signature	M.	,		020	(301	
	Registr	ar	JUN 2 3 200	O fless	is pos	She I					

ysiciar Iedica	Decedent's Name	(First, Middle, La	ist)	Phy G856	-6/23/	tificate of		-	. Date of Deat Month	Day	Year	3. Time of Death
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amine						4b. City, Town,		t Death		4c. Count	ty of Death	
eral	400 Mill 5. Social Security Nur			7. Age (In yrs. la	st birthday)	Balti If Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birth		9. Birth	place (State or Forei
ctor	213-36-44	83	1 ∑ M 2□F	67	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, Iay 11,	1939	Kent	ntrv)
7 100	Usual Residence of D	Decedent 10b. County		10c City	Town or Lo	cation						10d. Inside City Limi
2 8		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ltimor							1√2 Yes 2 □ N
other traumatic event, the Nedical Examinatinust be nutified at To Re Commissed by Finneral Director	10e. Street and Numb	per		ра.	TCTMOL	10f. Zip Code			1	0g. Citizen of	What Cou	
	400 Mill	ington /	Avenue	#227			21229			USA		
hy Finarai	11. Marital Status		12. Was Dec Armed F	cedent Ever in U.S orces?	13. \	Vas Decedent of f Yes, specify Cut		gin? (Specif	y Yes or No-	14. Ra	ce - Americ	
u z	1 ☐ Never Married 3 ☐ Widowed 4		1 Yes If Yes, G	2 ☑ No ive ⊃ates:		I ☐ Yes 2√∏ No			,		♭: whi	
7		5. Decedent's E	L	Jates:	16a. Deced	lent's Usual Occu	pation			16b. Kind of E		
Completed	(Specify Elementary/Second	only highest gra	ade completed,	(1-4or 5+)	(Give	kind of work done OO NOT use retire	during most	of working		roo. rand or E	Justi 1633/111	austry
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00	u 17. Father's Name (Fi	irst, Middle, Last)			unk			irst, Middle, M		тө)	
٢									allend:			
	19a. Informant's Nam Rose Jac		* .	use		g Address <i>(Stree</i>)7 P ine]						21229
	20a. Method of Dispo-			20b. Pla	ce of Dispos	sition (Name of		Date		20c. Location	-	
.	1 Burial 2 C	Cremation 3		COL	metery, cren	natory`or other pla	ice)					, , , ,
8500	21. Sign vurs a Fune RO			trector		Name and Addr ate Anat			55 W.	Baltim	ore S	treet
	23a. Par 1. Enter the	disease, or com	iplications that	caused the death.		ltimore, or the mode of dy			espiratory arre	st.		Approximate
an	Immediate Cause (Fi	failure. List only inal	one cause on			dd = tot	• 6					Interval Between Onset and Death
al	disease or condition resulting in death)	-	a Due to	(or as a conseque	ence of):	rnythemic						24 4185
er	Sequentially list cond	titions	b			heanto	liseare	e				1042
- au	Sequentially list cond if any, leading to imm cause. Enter Univerly Cause (Disease or inj	ediate	Due to	(or as a conseque	ence of):							
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1 4	IF FEMALE: 23b. Was decedent p			itcome of pregnant birth 2 🗆 Fetal o		Ectopic pregnanc	v				ite of delive	,
an/Ma	in the past 12 m			nant at time of dea		Other (specify) _	,			Mo	onth	Day Year
sician/Mo	1 Yes 2 I								00 - Dida	acco use con	tribute to th	ne cause of death?
Physician/Me	1 Yes 2 7 9 Unknown	ant conditions of	contributing to c	leath but not result	ting in the un	derlying cause an	en in Part I			s 2 No	3 ☐ Prob	,
2	articollida significa		contributing to c		ting in the un	derlying cause gr	ven in Part I.					
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2	articollida significa				ting in the un	derlying cause gr	ven in Part I.		1 ☐ Ye 24a. Was ar autopsy perform	ed?	prior to cor death?	npletion of cause o
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			1 - For State Registrar	State of Ma			rtment of H tificate of I		Menta	al Hygiei Rag.	ne2 () (No.	16	19873	
	Physici	an	1. Decedent's Name (First, Middle, Las	n(Mo			Year	3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Dea	Ju		4c. County o	Death	8:46 A M	
			University of	anyland Me	edical sys	tem	Balti	more		Baltimore City				
	Funeral Director		5. Social Security Number 6. S 219-26-7335		e (In yrs. last blirti 66 y	iday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Dat 7/2	e of Birth onth, Day, Yes 26/39	ar)	9. Birthp Cour Mar	place (State or Foreign ntry) y land	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation					1	10d. Inside City Limits	
	death with the Maryland ms 23a or 28a-1 ehow I'must be notified at	ctor	PA n/a	a	Yo	rk							1 XYes 2 □ No	
	with the	Funeral Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of WI	nat Cour	ntry?	
	eath v	erai	3115 Sorrel Sta	12. Was Decedent B	Ever in U.S.	13 W		404	Spacify Vo	s or No	USA	Amoria	can Indian,	
036	hours after death with the Marylan turel', or itams 23s or 28s-f show al Examiner must be motified at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Agned Forces? 1 A Yes 2 A A If Yes, Give I Year or Dates:			as Decedent of Hi Yes, specify Cuba □ Yes 2ሺ No	Specify:	to Rican,	etc.)		White,	etc. rican-	
ů Č	ğ 3 3	eted	15. Decedent's Ed (Specify only highest gra		16a. I	Decede Give k	ent's Usual Occupa ind of work done of O NOT use retired	ation Juring most of wo	rking	16b.	Kind of Bus	iness/Ind	erican _{dustry}	
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Maryland	should b ind Ments marked umatic a	To	William King					Beula						
Mar	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		19a. Informant's Name/Relationship (Address (Street a							
<u>ē</u>	s 1 end f Healt item 2 other	1	Nora A. King/ V 20a. Method of Disposition		20b. Place of I	エン Disposi	Sorre1 tion (Name of atory or other place	Street	Date Y C	20c.	A Location - C	/ 4 () 2 ity or To	t own, State	
Ē	00 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Garris	on	Forest	6/28					ls, MD	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Inneral Service Icen	See Marie	_	92	Name and Addres	s of Facility Wy erty Rd	lie ., R	F/II I landal	A. o	of I	MD 21133	
ı			23. Part. Enter the disease or com	olications that caused one cause on each lin	the death. Do no	t enter	the mode of dying	, such as cardia	c or respira	atory arrest,			Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a taxic	lung	1	mina						Onset and Death	
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	D 14 =	ner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of						_			
	icate be executed physicien and t	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Presto (or and	te consequence of		rcer							
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O. BOX	requires that the death certificate be executed een signed by the attending physicien and tould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		ctopic pregnancy Other (specify)				23d. Date Month		ery Day Year	
Ž,	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in t	he und	lerlying cause give	n in Part I.	236	. Did tobacco	use contrib	ute to th	e cause of death?	
ğ	equire ten sig ould b									1 🗆 Yes	2 No 3	☐ Proba	ably 4 □Unknown	
E E	The law ete hes b page 2 sl	Completed								. Was an autopsy performed?	prio	re autop or to com th? Yes	psy findings available inpletion of cause of	
VITAI	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			0.1	26. Place of Dea	ath Check	only one)				
on or	Phy this	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	nt 2 ER/Outp y 28b. Tir Year) Inji	ne of	28c. Injury Work	4 🗀 Mursing F	1	Residence scribe how in		(Specify	9	
DIVISION OF	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm . (Specify)	n, stree			28f. Loca City	ation (Street a or Town, Sta	and Number te)	or Rural	l Route Number,	
	na Hospil 24 hour ne Funeri	edical (29a. Certifier 1 La Certifying Phyone) 2 Li Medicai Exam	ysician: To the best of liner: On the basis of and manner stat	examination and/	death o	occurred at the time stigation, in my op	e, date and place inion, death occu	, and due	to the cause(time, date a	s) and mann nd place, and	er as sta d due to	ated. the cause(s)	
	To th	ž	29b. Signature and title of certifier	1 0			29c. License				ate signed (i		, ,	
	1		100	M.D				435116	662	Jui	1e 21	. 7	006	
	b		30. Name and address of person who of SIK HUL M.P.	22 SOV	ith ac	en:	e St. P	a times	(e. 1	40 -	2120	Ď.		
	Sta		31. Date filed (Month, Day, Year) JUN 2 3 2001	2. Registra	r's Signature	have	r)	,,,,,,,,		- Carlot	0	-		
	Registr	ar	JUN 2 3 2001	The was	N. W									

State of Maryland / Department of Health and Mental Hygiene) 9874 1 - For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** KLUVER RARBARA 9:024 TUN 20 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Dec 2, 1933 Birthplace (State or Foreign Country)
 NY Funeral 1 □ M & □ F Months Days Hours 72 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Approx Items 23e or 28e-f ehoviner must be notified at Howard Dayton 1 ☐ Yes 2 No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4940 Ten Oaks Road 21036 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. i Health and Mental Hygiene. item 27 le marked other then "natural", or Item other treumetic event, the Medical Examinal. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Be Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Clerical Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H lent: If item 27 is marked of George Butcher Regina 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Christina Goddard-Westfall 4205 Wards Chapel Rd., Marriottsville, MD 21104 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) = 5 permit. Page Department of Importent: If any injury or once. 6/21/2006 All County Cremation Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400 400764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** robable 15c /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 1 ☐ Yes 2 ☐ No 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 1 Yes VINo of Vital or Attending Physicien: funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending K investigation 1 TYes Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide in by determined 4 T Homicide after within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (kem 23a) (Type, Print) Colum NUE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 3 2006 Registrar

			1 - For State Registrar		Maryland		artment rtificate					iene og. No.	2006	19875
	Physici	an	1. Decedent's Name (First Middle	, Last)		-		V	c		2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution	nive street and num	nber) .		4b. Gity, T	Town, or	Location of	of Death	Sung	4c. Co	unty of Death	6-494
7	Examin	ier	The Tobac	Hopkins	Hospit	1	BA	12.	2000	E Court		40.00	unity of Obdit	'
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1	1 Year Days	If Under Hours	24 Hrs.	8. Date of Birth (Month, Day,	Vear	9. Birth	place (State or Foreign
	Director		213-20-8659	M 2□ F	83	Yrs.	Moritina	Days	riours		06/28/1			th Carolina
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Marylan I-f ehow fied at	to	Maryland			Ra 1	timor	0						1 XYes 2 No
	th the	Funeral Director	10e. Street and Number		1.	Бат	10f. Zip				10	g. Citizer	of What Cou	untry?
	23a c	al	3007 Rosalind	Avenue				2121	5			U.S.	Α.	
	er dez	une	11. Marital Status	Armed For		5. 13.	Was Decede If Yes, speci	ent of Hi fy Cuba	spanic Ori n, Mexicar	igin? (Spec n, Puerto R	cify Yes or No- lican, etc.)	14.	Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ∐ Yes If Yes, Give Year or Da	3		1 ☐ Yes 2	No No	Specify:			Sp	ecity: Bla	ack
21215-0036	ilied within 72 hours after death with the Maryland Yygiene. ther then "natural", or Iteme 23a or 28a-f ehow int, the Medical Examinar must be notified at	ted	15. Decedent	's Education		16a. Dece	dent's Usual kind of work	Occupa	ition			16b. Kind	of Business/li	ndustry
215	within 7 ene. then "r	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use	e retired,))	t or working				
	filed w Hygier Ither th		0 17. Father's Name (First, Middle, I	(act)			Labor	er	19 Mothe	ode Namo	(First, Middle, N		Compa	any
anc	d be fi	Be c	Benjamin Kinar							ie Ly		alden Sul	mame)	
Maryland	and Menistration	ဥ	19a. Informant's Name/Relationsh			19b. Maili	ng Address	(Street a			Route Number,	City or To	own, State, Zi	ip Code)
	1 and 2 Health a em 27 is		Lillie Pearl Mc	Clinton/ N	Niece	3007	Rosal:	ind	Avent	ie, B	altimor	e, Ma	ryland	1 21215
ore	of He of He if Item or oth		20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal from S		ace of Dispo metery, crea	natory or oth	e of her place					ion - City or T	
Baltimore,	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (S _I	oecify)	Mt.	Zion								Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Sure 12 from 27 is marked other than "natural", or Iteme 23s or 28s-f ehov any injury or other traumatic event, the Madical Examinational De notified at Once.		21. Signature of Funeral Service	License		46	Name and	Addres rk H	s of Facilit	The Ave.	Derrick , Balti	C. J	ones I Maryl	F/H, P.A. land 21215
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the death. ich line.	. Do not ent	er the mode			/		st,		Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. EN	ID S	tac	3e	De	me	nt	1a			notks
	Examiner			Parc	Kin So.	nence of):	Y)							leaves
	-31 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (c	or as a consequ	ence of):	'							12913
	nd nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с	Ei									
760,	ite be executed iysicien and he burial-transit		resulting in death) Last	Due to (d	or as a consequ	ence of):								
687	physi s the t	dicai		d										
Box (leath certifical attending phy I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo			7-					23d.	. Date of deliv	rery
	Physician: The law requires thet the death certificate be executed this certificate has been signed by the attending physicien and rial director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		nth 2 □ Fetal ant at time of de won]Ectopic pre] Other (spe						Month	Day Year
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	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examinar: On the ba and mann	sis of examinati	vledge, deatl	h occurred a vestigation, i	t the tim in my op	e, date an inion, dea	d place, an	nd due to the ca	use(s) and te and pla	d manner as s	stated. to the cause(s)
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	2		30. Name and address of person	() 1	of death (Item	23a) (Type,	Print)							
11	<i>U</i> .		Juson 31. Date filed (Month, Day, Year)	7 au 0 1.	gistrar's Signati		VORH	W	offe	ST	Dalti	More	Mary	land 21287
	Sta Registi		JUN 2 3	2006	ene h	& do	well.							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Veronica Keller May 12, 2006 2:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 222 S. Potomac Street Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 338-07-4155 90 Director Jan 24, 1916 Illinois Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 222 S. Potomac Street 21740 USA or Items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Yes, Give Specify: white 3 Widowed 4 Divorced Year or Dates: natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 office manager other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If item 27 is marked oth ery liquy or other treumatic event <u>once.</u> 18. Mother's Name (First, Middle, Maiden Surname) Be John P. Purcell Veronica Forbes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 S. Potomac Street Hagerstown, MD Russell Keller/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☑ Donation 5 ☐ Other (Specify) Ronald S. Wades Vitector State Anatomy Board 655 W. Baltimore Street mans Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medicai as by the attending pached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by been si 1 TYes 2 🗹 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed s certificate has 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ē Medical Certification: To (his funeral 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural death. 1 Tes 2 No veithin 24 hours after death To the Funerel Director; / c_mpletely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 4/66 Wellon

State Registrar

31. Date filed (Month, Day, Year) JUN 2 3 2006

Michie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ma

3 🖄 2. Registrar's Signature

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Please Type or Print in Black Indelible Ink

Jessica Klemkowski State of Maryland / Department of Health and Mental Hygiene 2006 19877 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day June 20, 2006 **Medical Examiner** Jessica Renee Klemkowski 0535 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 216-98-9445 Foreign Months Days 01/14/1979 Director M 2 X F 27 Yrs Usual Residence of Decedent any 10b. County Oc. City, Town or Location 10d Inside City Limits MD Anne Arundel - Pasadena items 23a or 28a-f show ust be notified at once. X Yes 2XXNo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Baltimore City 10e. Street and Number 3533 3rd Street 10f. Zip Code 21225 10g. Citizen of What Country? 180 Meadow Road United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black must be Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. Yes White 3 Widowed 4 Divorced f Yes. Give Year Yes 2XX No specify Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical ltimore, MD 21215-0036 Telemarketer 11 Telemarketing 0 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jerome S. Klemkowski, Jr. Be Sharon L. Paskoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome S. Klemkowski, 180 Meadow Rd., Pasadena Maryland 21122 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery or other 06/24/06 Baltimore Maryland Other Specify: Donation 5 Signature of Funeral Service License Signature of Funcial Service Licenses

22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

April iniury **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Cocaine and narcetic intoxication with complications Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and sician/Medical item#10b-f.19a, perinf, 2857, 7/18/06 TT item#23a, 27, 28a-f, periff, 2858, 8///6 TI XX UNPENDED the attending physician led for use as the burial -**X** AMENDED Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760. IF FEMALE: 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death 2 Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 ✓ Yes 25. Was case referred to medical 26 Place of Death (Check only one) of Vital Be examiner? Other₄ 1 / Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 🗸 Yes ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c Injury at Work' Certification: Division 1 Natural death 5 Pending Fnd 6/19/2006 To the Funeral Director: unk 2 ___ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2000 Blk. Wilkens Ave 6 XXCould not be 3 Suicide determined 4 Homicide found on street Baltimore 29a Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mu O.C.M.E June 21, 2006

31. Date filed (Month, Day, Year) State JUN 2 Registrar

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

December 1 March 2007 (March 2007) Alma Kelly 1 March 2007 (March 200				1- For State of Maryland / Dep. Registrar Ce	artment of Health and rtificate of Death	Mental Hygie	14-969 ARE ARE ARE	19878
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John Valyan MD D51051 June 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andres Salazar 3621 Ligen Rd, Ellicott city, MD 21042 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	5	Physi this al dir		1 Tes 2 Mino 1 Inpatient 2 EH/Outpatie	nt 3 DOA 4 Whursing			fy)
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DHMH 17 Rev 1/2001

1-	For State Registrar
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			1 - For State Registrar	otato ot mary	Ce	rtificate of	Death	Orna,,	Reg. N	<u>2</u> 000	10010
			1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	eath	ay Year	3. Time of Death
	Physicia /Medic		Susan Elizabet	h Leinbach				June 1			1:15 P ^M
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		Å.	Casey House Hosp 5. Social Security Number 6. S		yrs. last birthday)	Rockvil If Under 1 Year	Le If Under 24 Hrs.	9 Date of Bi	1	Montgome	
55	Funeral Director			1□M 2\ F 39		Months Days	Hours Min.	8. Date of Bi (Month, D. Nov • 2	av Year	1966 Io	thplace (State or Foreign ountry) Wa
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	th the	lrec	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	ountry?
	23e c	a	4400 East West Hi	ghway Apt#	723	208	14		U	.S.A.	
	or Items	nue	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, it a Medical Examiner must be notified at	by Funeral Director	1 🛱 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:			Specify: Whi	ite
5-0	2 should be illed within 72 hours and Mental Hygiene. Ie marked other than "naturel", " surnatic event, I'm Medical Exa-	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occup	nation during most of workii d)	ng	16b. l	Kind of Business	/Industry
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2	Hygie ther ther	ပိ	17. Father's Name (First, Middle, Last		WIJ	LCCI	18. Mother's Name	(First Middle	1		
an	id be ental ked o	To Be	Samuel Packard I		,		Julia Anr			. '	
ary	shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	l Route Numb	er, City	or Town, State, 2	Zip Code)
	and 2 lath a lath a 27 to er tra		Samuel P. Leinba	ich, Jr.(Fath	ner) 317	Fairmont	Ave., Win	ncheste	er,	VA 22601	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 le eny injury or other tra once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		Ob. Place of Dispo cemetery, cres	osition (Name of matory or other place		ate	20c. l	ocation - City or	Town, State
Ĕ	Pag ment tant: I		4 □Donation 5 □ Other (Special	(y) F	Belmond (6/20/		Вe	lmond, I	.A
3alt	permit. Departr Importuent injugence.		21. Signature of Funeral Service Lices	×500)	22 A	2. Name and Addre	ss of Facility uneral Hon	ne			
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	death. Do not ent	er the mode of dyin	ig, such as cardiac o	r respiratory a	irrest,		Approximate Interval Between Onset and Death
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Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year
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Q .	s that ned b e deta		Part II. Other significant conditions of	contributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
rds	quire en sig ruld b	ed b						1 🗆	Yes 2	X No 3□Pr	obably 4 Unknown
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/ita	hysicien: The law his cartificate has I I director, page 2 s	Be (25. Was case referred to medical examiner?				26. Place of Death				
of	Physicien: r this cartific ral director,	2	1 ☐ Yes 2 No		2 ER/Outpatien		4 Nursing Hon				city)Hospice
Division of Vital Records,	ding After funer	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Worl	yat k? Yes 2 □No	8d. Describe	how inju	iry occurred	
isi	deatl deatl ctor: y the	flca	2 Accident Investigation 3 Suicide 6 Could not b	e One Place of Injury	At home, farm, str.			8f. Location (Street a	nd Number or Ru	ıral Route Number,
Ö	aftar aftar Dire	erti	4 Homicide determined	building, etc. (Sp	pecify)	, (20.07), 0.1100		City or To	wn, Stat	9)	ar riodio realibor,
	To the Hospital or Attending Phenith 24 hours after death. To the Funerel Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying Pr	ysician: To the best of my	knowledge, death	n occurred at the tim	ne, date and place, a	nd due to the	cause(s	and manner as	stated.
	he Hi in 24 he Fu	Medical	one)	niner: On the basis of examiner stated.	mination and/or in	vestigation, in my of	pinion, death occurre	d at the time,	date an	d place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and tille o certifier	_		29c. License	e number		29d. Da	ite signed (Monti	h, Day, Year)
						D3563	35		Jun	ie 16, 20	006
i	12		30. Name and address of person who				Dooler-1	110 M	0 20 1	on d	
	Sta	te	Joseph Kaplan, M. 31. Date filed (Month, Day, Year)	32 Registrar's S			l., Rockvi	тте, М	aryı	.dIIQ	
1	Registr		JUN 2 3 20	06 Mesura	ignature	WELL					

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Marylan	•		of Health a of Death	ınd Mentai	Hygie Reg	400	5 19880
		Decedent's Name (First, Middle, Last))				2. Date of	of Death		3. Time of Death
Physic /Medi		Irene Louise Light					May	30,	2006 Yea	″ 10:15 PM
Exami		4a. Facility Name (If not institution, give			,	wn, or Location o	f Death		4c. County of De	
		National Naval Med	ical Center		Bethes				Montgome	ery
Funeral Director		379-40-6870	7. Age (In yrs. 84	ast birthday) Yrs.	If Under 1 \ Months D	ear If Under 2 ays Hours	Min. 8. Date of (Montile May	of Birth h, Day, Y 27	9. E 1922 Cai	Birthplace (State or Foreign Country) Nada
and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	, Town or Lo	cation					10d. Inside City Limits
Manyl 4 sho	ō	VA Fairfax	Spri	ngfield	£					1 Yes 2 No
permit, Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Modical Examiliar content and the notified at 2008.	Funeral Director	10e. Street and Number 5225 Perth Ct.			10f. Zip Cd			10g US	. Citizen of What	Country?
ns 23	era		12. Was Decedent Ever in U.	S. 13. V	Was Deceden	of Hispanic Orio	jin? (Specify Yes	or No-	14. Race - Ar	merican Indian,
or Iter	F	1 ☐ Never Married 2 🖾 Married	Armed Forces? 1 ☐ Yes 2 No	'	fYes, specify 1 □ Yes 2 🖸	Cuban, Mexican	, Puerto Rican, etc	.)	Black, W	
ural',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			No Specify:			Specify: W	nite
"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	dent's Usual C	ccupation lone during most etired)	of working	16	b. Kind of Busines	ss/Industry
withir ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	Homema		eureu)		Ov	vn Home	
filled Hygi othar ent, I		17. Father's Name (First, Middle, Last)				18. Mother	r's Name (First, Mi	ddle, Mai	iden Sumame)	
ould be Mental arked	To Be	Thomas John MacDou	gall			Mary	Louise W	illia	ems	
d 2 shouth and traums		19a. Informant's Name/Relationship (Ty Max H. Light - Hus					r or Rural Route N ngfield,			, Zip Code)
s 1 and 1 heal	11	20a. Method of Disposition	20b. P		sition (Name on atory or other	_	Date		c. Location - City	or Town, State
Pages ent of nt: If i		1 ⊈Burial 2 ☐ Cremation 3 ☐ P 14 ☐ Donation 5 ☐ Other (Specify)					6/27/06	Ar]	lington,	VA
permit. Departm Importa any inju		21. Signature of Funeral Service Licens	* Long 1	22	Name and A	ddress of Facility	Demaine Rd. Sprin	Fune	eral Home	e 22151
1		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the death	. Do not ent	er the mode o	f dying, such as	cardiac or respirate	ory arrest		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Sepsis							Onset and Death
/Medical		resulting in death)	Due to (or as a consequ	uence of):						
Examiner		Sequentially list conditions.)							
be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):						
and and III-tran	хап	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						1
icate be executed physician and s the burial-transit	= H									
ificate g phys	edlcal		d							
n certi	II/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		Te				23d. Date of d	elivery
death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregr Other (specif				Month	Day Year
at the by the	hys	9 🗆 Unknown						-		
Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	by	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the ur	nderlying caus	e given in Part I.				to the cause of death? Probably 4 Dunknown
aw requir s been si s should	olete							Masan	24b. Were	autopsy findings available
ding Physician: The lav h. After this certificate has funeral director, page 2	Completed						1 Y	autopsy performed es 22	d? death?	o completion of cause of es 2 No
ilan: intifica	BeC	25. Was case referred to medical examiner?				26. Place	of Death (Check o			20110
hysic his ce Il dire	10	1 ☐ Yes 2 ☐XNo	lospital: 1 X Inpatient 2	ER/Outpatien	t 3□ DOA	Other: 4 Nur	sing Home 5 🗆 I	Residence	e 6 □Other (Sp	pecify)
fter	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		ibe how i	injury occurred	
Attanding r death. actor: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be	One Blees of Isings At he		M	1 ☐ Yes 2 ☐ N		(Ctros	4 4 6 1	2
after d after d Diract	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, ramn, stre	eet, ractory, or	rice		Town, S		Rural Route Number,
To the Hospital or Attandi within 24 hours after death. To tha Funeral Director: A completely filled in by the t	edical C	29a. Certifier 1 Certifying Physic (Check only one)	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the contract of th	ne time, date and my opinion, deatl	f place, and due to h occurred at the ti	the caus me, date	e(s) and manner and place, and di	as stated. ue to the cause(s)
o the ithin o the omple	Med	29b. Signature and the of certifier	A./		29c. Li	cense number		29d.	Date signed (Moi	nth, Day, Year)
- s - o		· 11/4/1	1		i	697	(HI)	byer	TUNIO	2001
10		30. Name of ddress of erso who co	ompleted cause of death (Item		Print)				JUN9.	
10		ROBERT N. LCDR	,		NA' HETHI	FIONAL	NAVAL N 20889-	EDI	CAL CEN	ITER
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	89		 	3000		
Regist	rar	HIN 2.3.2006	Killing are St	13 1000	1900					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylar		artment of Health			iene _{eg. No.} 20	06	19881
	ė v		1. Decedent's Name (First, Middle, Last)	, ,	_			2. Date of Deat	th Day	Year	3. Time of Death
	Physici /Medic		Mary Loui	se Lauf	6			June 2	21, 20		11:04AM
S	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or Locatio			4c. County	of Death	
			Carroll Hospita	1 Center		Westmins	ter		Carr	011	
	Funeral Director		210 07 37 12	м Ж F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year If Und Months Days Hours	er 24 Hrs. s Min.	8. Date of Birth (Month, Day, Aug • 11	, 1916		place (State or Foreign ntry) rylan d
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	sho	'n	MD Carrol		Finks						1 ☐ Yes 🏋 🕅 No
	28a-1	ect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Cou	ntry?
	with	2	2401 Shawnee Dr			21048		'	•	S.A	•
	leath	era		2. Was Decedent Ever in U	J.S. 13.		Origin? (Spec	cify Yes or No-			can Indian,
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dep. dramal of Heatih and Mental Hylgiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, It a Michical Examination is not inferent and once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates:		Was Decedent of Hispanic (If Yes, specify Cuban, Mexic 1 ☐ Yes XX No Specif		lican, etc.)	Specify	k, White,	etc. hite
3	2 hou	ed	15. Decedent's Educa		16a. Dece	dent's Usual Occupation			16b. Kind of Bu	siness/Ir	dustry
2	nin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of work done during m DO NOT use retired)	ost of workin	g			•
<u> </u>	l with liene r thai	Eo	Elementary/Secondary (U-12)	College (1-4or 5+)		Bridal Reg	istra	ar	Hutz1e	rsI	ept.Store
2	Hyg othe	Be C	17. Father's Name (First, Middle, Last)			18. Mor	ther's Name	(First, Middle, M	Ma <i>iden S</i> u <i>m</i> am	e)	
Ö	ld be lenta ked ic av	To B	E. Ralph Raver			Ethe	el Ger	trude	Upper	20	
2	shound N	_	19a. Informant's Name/Relationship (Typ			ng Address (Street and Num					
Ž	alth a 27 is		Carolyn Caples,	/ Daughter	1507	Pilgram La	ne; F	inksbu	ırg, MI	D 21	.048
ב ב	t He Item		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place)	Da	ate	20c. Location -	City or T	own, State
2	Page nt: If ry or		XXBurial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	Emo	ory Ch	urch Cemete	ry 6/	29/06	Uppe	rco	, MD
	porta		21. Signature of Funeral Service License		22	2. Name and Address of Fac	cility Eck	hardt	Funera	a 1 C	hapel P.A.
Ď	Dep Impo		Juennet 1	num		.605 Reister					-
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause, (Disease or injury)	Due to (or as a consecutive to (or as a consecutive)			as cardiac of	respiratory am	esi,	/.	Approximate interval Between onset and Death
,00/00	certificate be executed iding physician and ise as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):				·		
C. DOX		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → Ho 9 □ Unknown	c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3[Ectopic pregnancy Other (specify)			23d. Dat Mor		ery Day Year
ras, r	law requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying cause given in Pai	rt I.	23e. Did tob			he cause of death?
วั	s bee	Completed						24a. Was a	n 24b. V	Vere auto	opsy findings available
ב	0 5 0	E						autops	ned? d	leath?	mpletion of cause of 2□ No
U	ician: The certificate rector, pag	a	25. Was case referred to medical			26. Pla	ice of Death	(Check only on			2 100
>	Physician: r this certifica ral director, j	0 8	examiner?	ospital: 1 panpatient 2	ER/Outpatier	Othor			ence 6 Othe	er (Speci	(v)
	er thi	i i	27. Manner of Death	28a. te of Injury (Month, Day Year)	28b. Time o				ow injury occurr		,,
0	Attending F ir death. ector: After by the funera	atio	1 Datural 5 Pending 2 Accident investigation	(Worth, Day 16ar)	Injury	M 1 ☐ Yes 2	□No				
DIVISION	al or Attendii s after death. al Director: A ad in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office	21	8f. Location (St. City or Town		er or Rura	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) Check only one)	cian: To the best of my known: On the basis of examination and manner stated.	owledge, deat ation and/or in	n occurred at the time, date vestigation, in my opinion, d	and place, ar leath occurre	nd due to the ca d at the time, da	ause(s) and mai ate and place, a	nner as s and due t	stated. to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier			29c. License numbe			9d. Date signed	1	
			Will Uli	MO		P00581	37		6/20	16	,
	1		30 Name and address of person who con	npleted cause of death (Item	т 23а) (Туре,	Print)	,	1 ,	1		102115-
	0		Wilbur Kyo	295 Stor	re/	Poos 8 (Print) Fre St 307	7 W	estan	heter	- N	12 01157
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Land &					

DHMH 17 Rev 1/2001

DUWALD 06-04080	TI	M ปีหนุ Léwis, JC. Please Type or Print in Black Indelible Ink
UNK UNK		State of Maryland / Department of Health and Mental Hygiene
		1- For State Certificate of Death Reg. No. 2006 1988
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last) Donald Timothy Lewis Jr. 2. Date of Death Month Day June 14, 2006 3. Time of Death 0815 hrs
Mar No.		4a. Facility Name (if not institution, give street and number) 922 East Preston Street 4b. City, Town, or Location of Death Baltimore City 4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Months Days Hours Min. Dec 25, 1985 Foreign Country) 9. Birthplace (State or Months Days Hours Min. Dec 25, 1985 Foreign Country) Md.
yland a-f show any t once.	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Funeral Director	1632 More and Ave 11. Marital Status 12. Was Decedent Ever in U.S. 15. Never Married 16. Never Married 17. Never Married 18. Was Decedent Ever in U.S. 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 10. N
2 hours after dea "natural", or ii Examiner mus	ğ	3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify: Spec
5-0036 iled within 72 he Hygiene. t other than "n: the Medical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) Memory Polyed 8. Mother's Name (First, Middle, Last)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Menlal Hygiene. In portant: If tiem 77 is marked other than "natural", injury or other traumatic event, the Medical Examiner	To Be C	Donald T. Lewis Sr. Marlene Madison 19a Informant's Name/Relationship (Type, Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
more, MD Pages 1 and 2 sh tent of Health and ant: If item 27 is		20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, parameter) 20c. Location - City or Town, State 20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: I'M Ty Cemetery Dundak, Wa. 22 Spinature of Funeral Solvice Licenson 22 Name and Address of Facility Joseph, L. Ryss, Funeral Home, P.A.
Physician /Medical Examiner		237 fat I. Enter tile disease, or complicions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List of ly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death
uted td ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):
exec in ar	edical	UNPENDED AMENDED
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. The this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trar	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown
, P.O. E ires that the casigned by the be detached	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	Completed	24a Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal R tian: 1 certific ector, p	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene
of Vig Physic Per this	5	1 V Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion c tending eath tor: Af the fun	ation	1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 No Subject shot
Division Spital or Attendia tours after death neral Director: A	Certification:	3 Suicide 6 Could not be determined (Specify) Parking Lot 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Parking Lot 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rear of 922 East Preston Street, Baltimore City
the Ho hin 24 } the Fu	Medical	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To wit	Mec	and manner stated. 29b. Signefule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 15, 2006
	1	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S Regis	tate trar	N NO MONEY
DHMH 17 Rev 1/2		ORIGINAL

06-03977 David Lange

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifi	cate of D	eath		Re	g. No.	100 1700
Physicia	an/	1. Decedent's Name (First, Midd	le,Last)			Date of Deat Month	h Day Year	3. Time of Death		
ledical Exami	ner	David Lange			La	O'1 T		June 10, 2	006	U326 Nrs
		4a. Facility Name (if not institution 6600 Manor Care Lan				City, Town, or Lo Rosedale	ocation of Deat	n	4c. County of Baltimore	
Funeral		5. Social Security Numbernk		e (In yrs. last b		f Under 1 Year Months Days	If Under 24Hr Hours Min			9. Birthplace (State ocunk Foreign
Director		212-72-8133	1 X M 2 F	49	Yrs.	Months Days	Hours Will	May 4,	1957	Country Mary Land
y	- [Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					Table leads Chillents
ow any		MD Balt								10d. Inside City Limits 1 Yes 2 X No
Aaryland 28a-f show 1 at once.	ģ	10e. Street and Number	шоге	Dall	imore	Of. Zip Code		140	g. Citizen of Wha	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland the and Montal Hygienie in 27 is marked other than "natural", or items 23a or 28a-fahr aritie event, the Medical Examiner must be notified at once	Director	74 King Charle	es Circle		l'	212	237		USA	at Country?
h with	Funeral		12. Was Decedent Armed Forces?			ecedent of Hispa specify Cuban, N		pecify Yes or No-	14. Race - White,	- American Indian, Black,
er deat	Fun			X No		V-	specify:	r trodit, oto.,		white
hours afte 'natural'' Examine	ğ	15. Decedent's Education (Spe	or Dates:	pleted) 16a				work done		
72 hou	eted	Elementary/Secondary (0-12)				of working life D				
215-0036 be filed within 72 ttal Hygiene ked other than ent, the Medical	omple	unk 12	unk	Di	sabled				none	
5-0 iled w Hygie I othe	ပ၂	17. Father's Name (First, Middle		•				e (First, Middle, M	laiden Surname)	unk
21215-003 uld be filed withi Mental Hygiene marked other tt	Be	Richard Lange, S					rolyn Ri			
MD 21 d 2 should Ith and Mei n 27 is mai	ဥ	19a. Informant's Name/Relations O.C.M.E. Robe	ert Eisen/ execu	itor	9b. Maling	un Street Tenn St	#352 R	Rural Route Num E isterstow 11 timore	n, Mo 211	State, Zip Code)
r tra	- 1	20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal from Sta		of Disposition atory or other	(Name of ceme	etery,	Date	20c. Location - 0	City or Town, State
altimore, mit Pages I at partment of He portant: If ite			pecify: in state	ile i						
Baltimor permit Pages Department of Important: If		21. Signalure of Fune al Service Ronald		ector	Stat	e and Address o	f Facility ny Boar	d 655 W.	Baltimo	re Street
		o mun	Mixal	l	Balt:	imore,	MD 21:	201		
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.						st, shock, or hear	Between Onset and
Examiner	ĺ	Immediate Cause (Final disease or condition resulting in death)	a Hypertensiv		scleroti	.c cardiov	ascular	disease		Death
		Sequentially list conditions,	b							
	aminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):						
	cam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
executed an and al - transit	EX		d							
760, cate be exe physician the burial -	n/Medical	X UNPENDED	X AMENDED item	#5.9.11 #23.11	15.16a-	17,18,19 MF. 857.7	9a-b, per4	B,g857,7/6	06 TT	
8760, tificate be ng physicas the buri	N/	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregnanc	у	death 3			23d. Date of d	,
Sox 687 leath certific e attending 1 for use as t	Physiciar	past 12 months?		time of death		(Specify)	_Ectopic pregn	ancy	Month	Day Year
Box (e death or the attended for use	nysi	1 Yes 2 No 9 Uni	known 9 Unknown		- Other	(-1)				
P.O. s that the gned by e detache		Part II. Other significant condit		but not result	ing in the unde	erlying cause give	en in Part I.			ute to the cause of death?
S, P.C uires that n signed l d be deta	ed by	Diabetes Mellit	us							Probably 4 🗸 Unknown
of Vital Records, ng Physician: The law require of the continuation of the continuation of the control of the c	Completed							24a. Was a autops	y pri	ere autopsy findings available or to completion of cause of
Reco The law cate has	E							perform 1 V Yes 2		eath? ✔ Yes 2 No
tal Recionant The certificate ector, page	BeC	25. Was case referred to medica examiner?					f Death (Check	anly one)		
' Vit	일	1 ✓ Yes 2 No	Hospital 1 Inpatier		Outpatient 3				Residence 6	
n of ding Pl After funera	Ë	27. Manner of Death 1 X Natural 5 Pen	28a. Date of Injur (Month, Day,Ye	ry 28t ear)	. Time of Injur		at Work? s_2	28d Describe h	ow injury occurred	d
ivisior or Attencafter death Director:	cati		stigation	ive. At boson	fa			205 (0.		
Division tal or Attendi rs after death al Director: A	Certification:	dete	ld not be 28e. Place of Injurmined (Specify)	ury - At nome,	rami, street, r	actory, office buil	iding, etc.	or Town, St		or Rural Route Number, City
lospita Hour unera		29a. Certifier 1 Cortifuing P	hysician: To the best of my	/ knowledge d	aath accurred	at the time date	and place and	due to the course	e/s) and manner o	on storted
Division of Vital Records, P.O. Box 68760, within 24 hours death certificate be within 24 hours death. To the funeral Birector: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only	miner: On the basis of exan	_					. ,	
To To	Mec	29b. Signature and title of certific	and manner stated.			29c License r	number		29d. Date signed	i (Month, Day, Year)
ned		701 411	or Se.			O.C.M.	.E.		June 10, 20	06
(4) 2	1	30. Name and address of persor	who completed cause of de	eath (Item 23a)					
U	. 1	Zabiullah Ali, M.D.	Assistant Medical Ex	aminer	111 Penn \$	Street, Baltim	nore, MD 21	1201		4
Si Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar		hory	ويخ				

			For State Registrar	State of Mary			ent of He			ene 2 (06	19884
	Physici	an	1. Decedent's Name (First, Middle, Last)		1/	n - M ·//	20		2. Date of Death Month	Day _	Year	3. Time of Death
	/Medic	al	Tamia		/٧	1cmill			June 2	1 20C		0039 M
1	Examin	er	4a. Facility Name (If not institution, give s The Johns Hopk	. 11	istal		Baltimi	ocation of Death	tu	4c. County		1
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last bir	thday) If U	rder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Vocal	9. Birth	place (State or Foreign
L	Director		220 02 00 10	M 257 F	2	Yrs. Mon	ths Days	Hours Min.	6-16-0			Md.
	land ow	}	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town	n or Location		-				10d. Inside City Limits
	Mary Interior	to	Md. NA	7		Balti	more					1√∑Yes 2 ☐ No
	or 284	Director	10e. Street and Number 115 Robert Curbear	Tunior In	no		Zip Code 21221		10	g. Citizen of V USA	√hat Cou	intry?
	s 23a	rail										
36	be filed within 72 hours after deeth with the Maryland nat Hygiene. od other than "neturel", or Items 23e or 28e-f show event, the Medical Examinar must be nutified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	in U.S.	If Yes,	specify Cuban	panic Origin? (Sp , Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)		k, White,	ica <i>n</i> Indian, , etc. Black
9	72 hou	sted	15. Decedent's Educ (Specify only highest grade		16a.	Decedent's I	Jsual Occupat	ion iring most of work	ing 1	6b. Kind of Bu	siness/Ir	ndustry
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auc	a d a b	To Be	Tavon	Mc	Millor	n			elle	arderi Berram	Muri	ray
Maryland 21215-0036	should and Men e marke	۲	19a. Informant's Name/Relationship (Type	ое, Print)								p Code) 21221
	5 5 7 5 G		Tavon McMillon	Father				and the same of th	nior Lan			
Baltimore,	Peges 1 en Bent of Heal Int: If Item 2 Iry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R		cemetei		or other place)) 		Oc. Location		
Ë			4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	99	HOLLY		CEMETI and Address	ERY 6-24		Middle more, N		
ä	permit. Depertr Importe eny inju		& lady	Wane		Mai	cch F.H	. East		E. Nort		
			23a. Part1. Enter the disease, or compli- shock, or heert failure. List only or	cations that caused the e cause on each line.	death. Do	not enter the	mode of dying,	such as cardiac	or respiratory arre	st,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Cerebra	uH	lernia	tion					Onset and Death 5 day 5
	/Medical Examiner		ſ	Gliobla			الما الم	forme.				78 0016
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co			aciii	101710				20 days
	icate be executed physicien end s the burial-transit	Examiner	Cause (Disease or injury that iniliated events resulting in death) Last									
8760,	be exicien (al E	Tooling in county case	Due to (or as a co	nsequence	or):						
687	ficate physis the	edicai	\ d									
Вох	eath certifi attending for use as	M/W	230. Was decedent pregnant	3c. If yes, outcome of pr 1 □ Live birth 2 □		3∏Ecton	ic pregnancy			23d. Date	a of deliv	ery
о В	The law requires that the death certific ste hes been signed by the attending p page 2 should be deteched for use as	by Physician/M	in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	4☐Pregnant at time 9☐Unknown		5 Other	(specify)			Mor	ith	Day Year
P.O.	that the do	Phy	Part II. Other significant conditions con	tributing to death but no	ot resulting in	the underlyi	na cause given	in Part I.	23e. Did toba	acco use contr	ibute to t	he cause of death?
rds,	quires tha n signed uld be det	d b							1 🗆 Yes	200 No	3 🗌 Prol	bably 4 Unknown
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ot	Phys r this ral dir	<u>۲</u>	1 Yes 2 No	1 XInpatient 28a. Date of Injury	2 ER/Ou	tpatient 3	DOA Other	4 Nursing no	me 5 Resider			(v)
ion	nding ath. r; Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye		njury M	28c. Injury a Work?	s 2 No		. Injury cocur	,,	
Division of Vital Records,	ter desirence	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, fa	rm, street, fac	ctory, office		28f. Location (Stre City or Town,		r or Run	al Route Number,
۵	pital o		On Continue of Continue of the	laine Table base of								
	To the Hospital or Attending Physician: The within 24 hours elter death. To the Funeral Director: Attenthis certificate he completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	ician: To the best of my ner: On the basis of exa and manner stated.	mination an	dor investiga	red at the time tion, in my opir	, date and place, nion, death occur	and due to the cau red at the time, dat	use(s) and mai te and place, a	ner as s nd due t	stated. o the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier				29c. License			d. Date signed	(Month,	Day, Year)
	0		Deannange	Green	MC)	KES-	-000		June	21,	2006
	3		30. Name and address of person who co	mpleted cause of death	(Item 23a)	(Type, Print)	Baltin	noice M	D Z128	7		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	OT.	Dall	nare, 11/	1) 6160	/		
	Registr		JUN 2 3 200	32 Registrar's	Li.	GOONS	,					

06-04187

Please Type or Print in Black Indelible Ink Eva Medina State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2 Date of Death June 17, 2006 **Medical Examiner** 0037 hrs Medina 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs, 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign CountryMaryland Months Days Hours Director 584-37-8355 45 Feb. 26, 1961 1 M 2X F Usual Residence of Decedent 10b. County Oc. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. 1 X Yes 2 No Maryland Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland rector 10e. Street and Number 10f Zip Code 10g. Citizen of What Country 238 South Highland 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 White, etc. Married Yes 4 Divorced 1 X Yes 2 No specify: Puerto Rican Specify: White Widowed If Yes, Give Year traumatic event, the Medical Examiner ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "ninjury or other traumatic event, the Medical Ex Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Misael Medina Be Eva Medina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calle 419 Bloque 164 #3 Carolina, PR 00958 Hector Medina 20b. Place of Disposition (Name of cemetery Cate 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Jardin Del Eden Cem. 6/21/06 Cirda, Puerto Rico Depation 5 Other Specify 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Jardin Del Eden Umen Carretera #1 KM 486 Cidra, PR 00739 I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Cocaine intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical AMENDED item#23a,PII,2/,28a-f,perME,6856,6/28/06 TT AUNPENDED attending physician or use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Day Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown detached for Unknown the Phy Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Asthma 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Ceath (Check only one) Be examiner? Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this ဥ 1 V Yes 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 V No hours after death 6/16/2006 the Director: Fnd 11:50 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 239 S. Highland Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be within 24 hours at To the Funeral D determined (Specify) Found in residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. June 17, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

06-03897 Phillip Murray

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		I-For State Certificate of Death Reg. No.
Physicia	_	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
ledical Exami		Phillip Murray June 7, 2006 1145 nrs
the Same		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5001 Ready Avenue Apartment A Baltimore
_		5. Social Security Number un 1/26. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk
Funeral Director		1 Months Days Hours Min. Sept 9, 1957 Foreign Country)
any	-	Usual Residence of Decedent 10a State
*		MD Baltimore 1 X Yes 2 No
daryland 28a-f show 1 at once.	휧	10e, Street and Number 10f. Zip Code 10g Citizen of What Country?
or 28	Director	5001 Ready Avenue #A 21212 USA
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after o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: black
hours	eted t	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work donard during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk
36 in 72 han ",	Bet	Elementary/Secondary (0-12) College (1-4 or 5+) unk unk
5-0036 lled within 7 Hygiene. I other than the Medica	ompl	unk unk unk la.Mother's Name (First, Middle, Last) unk la.Mother's Name (First, Middle, Maiden Surname) unk
215 be filed ntal Hy rked of	Be C	
21.2 buld b 1 Men 1 marl		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD 21215-0036 td 2 should be filed within 72 hours after death with the Maryland tth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f she aumaite event, the Medical Examiner must be notified at once		O.C.M.E. 111 Penn Street Baltimore, MD 21201
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State
Page Page nent o		4 Donation 5 X Other Specify: in state
Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other tr	- 1	21. Signature of Fundament Service Licensee Ronald S. Wase Mirector State Anatomy Board 655 W. Baltimore Street
	-1	Baltimore, MD 21201 23a. Pan I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical		failule. List only one cause on each line.
Examiner		Immediate Cause (Final disease or condition resulting in death) a Right Intracerebral (Basal Gam lia) hemorrhage Due to (or as a consequence of):
,		Sequentially list conditions, b
	ē	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
	Examiner	Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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exe	Physician/Medical	x UNPENDED x AMENDED item#23a,27,28a,b,d,perME,g857,7/15/06 TT
760, ficate be g physici	We.	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
687 certifinding	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify)
Box 68's death certiff	ysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
O. B. at the de la the de la ched f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death?
, P.O.	d by	1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, rat or Attending Physician: The law requirms after dearth. The The The The The Instructors the This certificate has been sited in by the funeral director, page 2 should be	Completed	24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
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ion tendi eath. tor: /	aţi	1 X Natural 5 Pending 2 Accident Investigation Jun 7, 2006 1130 hrs 1 Yes 2 No
IVIS or At after d Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Divis spital or A hours after neral Dire	Se	4 Homicide determined (Specify) Multi Family Apt. 5001 Ready Avenue Apartment A, Baltimore, M
₹ 2 g ja		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Check only medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within 7 To the complet	Medical	and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
_	_	OCME THE C 2001
		30. Name and address of person who completed cause of death (Item 23a)
		Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
9	tate	
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State of Maryland / Department of Health and Mental Hygiene 0 0 0

			1 - State Registrar		Olule of Wi	ai y tai i	Cei	tificate of	Death	ivicinal riy	Reg. No.	UUb	198	0 1
	Dharisi		1. Decedent's Name (F	First, Middle, Last	")					2. Date of De		Year	3. Time of De	eath
	Physici /Medio		William J	. McCart	thy						NE 1	6,2006	8:46	Ам
1	Examir	er	4a. Facility Name (If no Saint .		street and number) Medical	Cen	ter	4b. Cily, Town, o	Tow		4c. Co	Balt	imore	
	Funeral Director		5. Social Security Num 216-30-006		X 7. Ag	e (In yrs. 75	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min		th ay, Year) 1931	9. Birthpl Count	ace (State or F try) U	Foreign nk
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	Maryle f sho	or	MD	Baltimo	ro	100.01		wson					od. Inside City I 1 ☐ Yes 2	
	286-	rect	10e. Street and Number		,16		10	10f. Zip Code			10g. Citizer	n of What Count		Δ
	h with	al Di	1209 Boyc	e Avenue	2				21204			USA		
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ā,	f Health		20a. Method of Disposi	ition			lace of Dispo	sition (Name of		Date PID	2120 20c. Locat	tion - City or Tov	vn, State	
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O. Box	that the death cert hed by the attendin detached for use is	Physician/M	IF FEMALE: 23b. Was decedent proin the past 12 mo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	1		23d	. Date of deliver Month [y Day Year	ır
rds, P	w requires that been signed b should be deta	by	Part II. Other significate SEPTIC ART		ntributing to death bi	ut not resu	ulting in the ur	iderlying cause giv	en in Part I.	23e. Did to	1/	contribute to the	cause of deatl	
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on	Attending I r death. ector: After by the funer	tlon		Pending investigation	(Month, Day	Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2∐No	28d. Describe h	iow injury oc	curred		
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	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edical	29a. Certifier 117 (Check only 25 one)	Certifying Phys Medical Exemi	sicien: To the best oner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and date and pla	d manner as sta	ed. he cause(s)	
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			30. Name and address						NOTHE T	OUCON A	desirate i	OND OA	(m. /	

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 2 3 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

,		- For State Control of Pleath and Worker Tigger		g. No. 200	6 1988
Physician Medical Examine	1	. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death 2115 hrs
neuicai Examine		John Edward Miller la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	June 19, 2	4c. County of Deatl	
		GBMC Towson		Baltimore Cou	_
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.		h(MM/DD/YYYY) 9. Bir Foreig	an
		216-20-6591 1X M 2 F 81 Yrs. Sual Residence of Decedent	Sept 2	1, 1924 Co	ountry)Maryland
w any	1	10a. State 10b. County 10c City, Town or Location			10d. Inside City Limits 1 Yes 2 X No
Aaryland 28a-f show Latonce.		Maryland Baltimore Timonium [Oe. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	
ith the Maryland 23a or 28a-f sh notified at once		2525 Pot Spring Road, unit S 220 21093		USA	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked to ther than "natural", or items 23a or 28a-f she marite event, the Medical Examiner must be notified at once To Be Commission by Europeal Director	runeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1 Never Married 2 V Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
fter de:		1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	White
hours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life, DO NOT use refin		16b. Kind of Business/	Industry
1215-0036 Id be filed within 72 hou fental Hygiene. narked other than "nat event, the Medical Exa	отріете	Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ Engineer		Aeronau	tics
5-0C filed wit Hygier I other the M	ין כ	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, M		
21215-0036 hould be filed within 7 hould be filed within 7 hould bygiene. is marked other than tite event, the Medical To Be Comple	9 1 0 1	James E. Miller Amanda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R		nknown by ber, City or Town, State	
MD 1d 2 shou alth and m 27 is 1 aumatic		Dorothy M. Miller/Wife 2525 Pot Spring Road,		um, MD 21	093
ore, tree		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 6/2	Date 24/06	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar permit. Pages I ar Department of Hec Important: If ite injury or other tr	-	4 Donation 5 Other Specify: Dulaney Valley Mem. Grdns.		Timonium,	Maryland
Ba Perm Depa Impo	٢	Bryan W. Clary Lemmon Funeral Hom 10 W. Padonia Road	ne of Du l. Timon	laney Valle	ey Inc. 1093
Physician /Medical	2	23a. Pari I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or fair re. List of young cause on each line.	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Txaminer		Immediate Cause Final disease or condition sulting in death) Ather Terotic cardiovascular disease Due to (or as a consequence of):			Death
	اي	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	، ⊇	cause. Enter Underlying Cause			
ecuted and transit		events resulting in death) Last Due to (or as a consequence of): d.			
ial ial	Medical	X UNPENDED AMENDED item#23a,PII,27,perME,g856,6/26/06 T	Γ		
8760, ifficate be exigonal physician is the burial		FFEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncy	23d. Date of deliver Month	y Day Year
Division of Vital Records, P.O. Box 68' Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending Funeral Director: After this certificate has been signed by the attending the fineral director, page 2 should be detached for use as the contract of the	Physician	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown			
that the de ned by the detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tol	pacco use contribute to	the cause of death?
ires tha	ğ	Mitral valve prolapse	1 Yes	2 No 3 Prol	oably 4 🗸 Unknown
ords, w requires been as been	Completed		24a. Was a autops	sy prior to	topsy findings available completion of cause of
tal Rec			perform 1 V Yes 2		es 2 No
Vital ysician:	o Be	25. Was case referred to medical examiner? 1 Very 2 No Other 1 Norsin		Residence 6 Othe	r:
Division of Vital Records, P.O rat or Attending Physician: The law requires that is a fler death. "In Director: After this certificate has been signed by the finneral director, page 2 should be detacted."		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
Sion Attend r death ector: by the f	ati	Accident See Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (S	treet and Number or Ru	ural Pauta Number City
Division of At hours after duneral Direct y filled in by	Certification:	Suicide 6 Could not be determined (Specify)	or Town, St		irai Route Nutriber, Oity
To the Hosp within 24 ho To the Fune completely f	<u>.</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a			
To To	ê :	and manner stated. 29b. Signature and title of certifier 29c. License number		29d Date signed (Mo	nth, Day, Year)
		O.C.M.E.		June 20, 2006	
\$	1	30 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	í		
Sta	55	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Registra	धार	JUN 2 3 2006 Regues & Coard			

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2006 12:05P M Frances Van Winkle McBryde June 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10100 Falls Road Montgomery Potomac If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 2, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1□M 2∰F Months 213-54-8290 95 1910 Utah Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28e-1 show any injury or other traumatic event, the Medical Experiments. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10100 Falls Road 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: þ 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Thorn Van Winkle Elva Hulburd Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19437 Transhire Drive, Gaithersburg, Maryland 20886 John M. McBryde / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 20, 2006 Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M01420 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Acute Cerebrovascular Accident 1 Day /Medical Due to (or as a consequence of): Examiner 6 Years <u> Hypertensive Cardiovascular Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗓 No Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2X No 1 Yes : After this certification of the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1X Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident filled in by the 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39501 June 19, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugh Holder, M.D. 101 Stonegate Drive, Silver Spring, Maryland 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State JUN 2 3 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		artment of Heartificate of De			iene 19. No. 200	6 19890
45	Dhusisi		1. Decedent's Name (First, Middle, La			2. Date of Deat Month	Day Ye	3. Time of Death		
	Physici /Medio	_	THOMAS JOS	4b. City, Town, or Location of Death			4c. County of D	-		
	Examir	er	4a. Facility Name (If not institution, give GOOD SAMAKI)	TAN HUSPITA	1	BAL91MOK			N/A	
**50	Funeral			Sex 7. Age (In yrs	s. last birthday) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
30	Director		212-30-6119 Usual Residence of Decedent	80	713.			Jan. 1,	1926	Ireland
	iryland		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits 1 □XYes 2 □ No
	he Ma 28a-1 s	Director	Maryland N/A 10e. Street and Number		Balti	More 10f. Zip Code		10	og. Citizen of What	
	3a or		4206 Powell Aver	110			206		U.S.A.	
	death	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispa f Yes, specify Cuban, N		crfy Yes or No-	14. Race - A	American Indian, Vhite, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "naturs!", or items 23a or 28a-1 show or other traumatic event, the Medical Exampliar maint by Indifficial.	by Fu	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 MYes 2 □ No If Yes, Give Year or Dates: Kore			pecify:	, , , , ,	0. "	White
Maryland 21215-0036	2 hour	ted t	15. Decedent's E	ducation	16a, Dece	dent's Usual Occupation kind of work done durin	n	.	16b. Kind of Busine	
215	ithin 7 ne. nan "r	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			. 1	
2	Hygier ther th		12 years 17. Father's Name (First, Middle, Las.	1)	1 1	Firefighter		-	Balto. Ci Maiden Surname)	ty Fire Dept.
au	iould be filed withing Mental Hygiene. Parked other than patic event, Ira M	To Be		McHale			Nora	Clar	·ke	
ary	2 should and Men is marke		19a. Informant's Name/Relationship	(Type, Print)						re, Zip Code) 21136
S O	fealth m 27 her tr		Linda Poggi 20a. Method of Disposition	(niece)		Billy Bart	on Circ		terstown 20c. Location - City	
non	ages int of the t: If ite		1 Surial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special Control of Contro	Removal from State	cemetery, crer	Cemetery	6-24-			e, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 sny injury or other once.		21. Signature of Funeral Service Lice							
<u> </u>	Depared Important Importan			naise		Name and Address of LICHELL-WI 6500 York	Road Ba	altimore	, Maryla	nd 21212
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	rplications that caused the de- rone cause on each line.	ath. Do not ent	er the mode of dying, si	uch as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical	9 11	Immediate Cause (Final disease or condition resulting in death)	a. SEVERE Due to (or as a conse	HYP	OXIC EN	ICEPHA	COVA	THY	
	Examiner		Conversation the first was distinged	MYOCLOI	VIC	8E12UR	E			
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):					
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8760,~	ate be executed thysician and the burial-transit	dica!		d						
9	artifical ing phy 8 as th	Medi	IF FEMALE:							
Box	death certific e attending p ed for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	ital death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
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ord	requir	Completed by Physician/Me	CARDIAC AR	, ,	-			1 🗆 Ye		Probably 4 Unknown
Division of Vital Records,	he law e has l	mpi		LYMPHOM			401	24a. Was ar autops perform	y prior death	
ita	iician: Th certificate rector, pag	Be C	 Was case referred to medical 	CARCINOR	nn oj	△1//Y 26	6. Place of Death	(Check only one		Yes 2□No
> <	Physician: rthis certific ral director.	၉	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2					nce 6 Other (5	Specify)
ono	ding P h. After I	tion:	27. Manner of Death 1 Natural 5 Pending 20 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?	2 🗆 No	28d. Describe ho	w injury occurred	
visio	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injury - At				28f. Location (Sti City or Town		r Rural Route Number,
ā	ital or A rrs after ral Dire			building, etc. (Spec						
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my ke miner: On the basis of exami- and manner stated.	nowledge, death nation and/or in	vestigation, in my opinion	date and Jace a on, death occurre	ind due to the re ad at the time, da	uise(s) and manna ate and place, and	r as stated due to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	MAD		29c. License nu			d. Date signed (M	•
		1	M.XON	L WIO		RES	000		06-21	-2006
	12		30. Name and address of person who NIVEDITA PAND	completed cause of death (It	em 23a) (Type,	Print) REAL RIVER	Q AI	TIMAR	MARI	CAND-2123
	-	ate	31. Date filed (Month, Day, Year)	/ 32. Heganiais Sig	nature) SAC	· imore	1 11/1/19	VE 111 6.63
4	Regist	rar	JUN 2 3	2006 Seren	J. J.	Coarle				
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Physic	ian	1. Decedent's Name (First, Middle, Las	2 Per Phy C8	56 6/23 ,	06 JH "		2. Date of Dea Month	Reg. No. ath 6-14-2006 Day	
/Med Exami		4a. Facility Name (If not institution, give	street and number)		4b. City. Town. o	r Location of Deatl	Jore	4c. County of Dea	2:45pm
Exam	ner	North week	HOSALLI C			listour		Boit-m	
Funera Director		Social Security Number 6. Security Number		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov 9,	h 9 Ri	rthplace (State or Foreign country) ryland
and w		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
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n the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
23a c	a D	3627 Marriott La	ne			207		USA	
be filed within 72 hours after death with the Maryland net Hygiene. d other then "naturel", or items 23a or 28a-f show event, the Madical Examinat must be notified as	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	ĺ	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🂢 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
within 72 ho iene. 'then "natur ine Medical.	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	unk king	16b. Kind of Business	s/Industry unk
filed v Hygie other t		10 17. Father's Name (First, Middle, Last)	0			18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	
should be nd Mentel marked o	To Be	Harry James O'Br	ien				ty Jane	,	
d 2 shi th and 7 ie m treum	-	19a. Informant's Name/Relationship (7 Betty Jane Hughes	• • • • • • • • • • • • • • • • • • • •	1	ng Address (Street Marriott			r, City or Town, State, MD 21207	Zip Code)
Peges 1 an ment of Heeli tent: If item 2 lury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	Removal from State		natory or other plac		Date	20c. Location - City o	
permit. Peg Department important: eny injury o		21. Signature Funeral Solvice Licen Ronald S	11/ Ille		altimore	, MD 212	201	. Baltimore	e Street
Physician /Medical Examiner		23a. Part 1 Enter the disease, or common shock or heart failure. List only the shock of heart failure. List only the shock of the shock	a. Due to (or as a con		er the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
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Physician: T this certificet ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		Oth		th Check only or		
anding Phys ath. or: After this ne funeral di	atlon; To	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o Injury	28c. Injun World	4 ☐ Nursing H y at k? Yes 2 ☐ No	ome 5 ☐ Resid 28d. Describe h	ence 6 Other (Spe ow injury occurred	ecify)
2 0 0 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp		eet, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
ital or Attend iss after death rai Director: /	67	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	vestigation, in my o	pinion, death occu	rred at the time, d	ate and place, and du	e to the cause(s)
the Hospital or Ati hin 24 hours after d the Funeral Direct upletely filled in by	Aedical				29c. Licens	e number	-	9d. Date signed (Mon	m. Dav. Yeari
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alea completely filled in by the fune	Medica	29b. Signature and title of certifier				2908	5 .	JUNE 14	•
To the Hospital or At within 24 hours atter d To the Funeral Direct completely filled in by	Medica	29b. Signature and title of certifier 30. Name and address of pe on who of		(Item 23a) (Type,	Print)	290 S	S .	JULE 14	2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 2006° **Physician** 17 10:a M Powell Rov /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 800 Dartmouth Rd. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **№** М 2 🗆 F 215-46-9352 N.C. Director 58 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits , or Itema 23a or 28e-f show the Medical Examinar must be notified at 1 XYes 2 No Baltimore NA Md Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 800 Dartmouth Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) J.H.H. 12th grade I.V. Specialist and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be inent of Health and Mental Int. If Itam 27 Is marked o Powell Tnez Unkn ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 704 N. Edan Street, Baltimore, Md. James Simmons Step-Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. 6-23-06 Lansdowne, Md. Mt. Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 la Warne 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Due to (or as a consequent of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☑ Minknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 1 Yes or Attending Physicien: ierel Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one 21 No Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 🗆 Yes Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Dilath 28b. Time of 28c. Injury at Work? Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Dire 4 | Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Uhwersity

of Maryland

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Pressley Janet 2006 7:00 P June 16, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖫 🤻 77 579 30 8667 Yrs. Director Oct 27, 1928 Washington DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Directo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? rthen "naturel", or Iteme 23a or the Medical Examiner must be 7321 Branchwood Terrace 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Slatus filed within 72 hours after Hygiene. 1 Yes 27 No If Yes, Give XX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify ģ White XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other then Retail Management Candy Store 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event 9DES. 17. Father's Name (First, Middle, Last) UNKNOWN Charles Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4525 Edsall Drive, Woodbridge, Va 22193 Jeanne Howard (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Burial 2 ☑ Commanion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 21, 2006 Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee — MO 1461 Alexandria Ferry Road, Clinton, MD PA1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio pulmonary arrest **Physician** /Medical Due to (or as a consequence of): Examiner Acute respiratory insufficiancy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit aspiration pneumonia resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, congestive heart failure Physician/Medical as attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes X No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did lobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were aulopsy findings available prior to completion of cause of death? autopsy performed? certificete 1 Yes ZONO 1 Tyes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury al Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 🗌 Pending 1 ☐ Yes 2 ☐ No I Director: A id in by the fi 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours af To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier allender 000 2420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abulhasan U. Ansari, M.D., P.C. 8926 Woodyard Road Ste 101, Clinton, MD 20735

JUN 2 3 2006

32. Registrar's Strature 31. Date filed (Month, Day, Year) State JUN 2 3 2006 Registrar

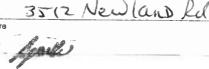
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9894 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P **Physician** Month ugene 2006 /Medical 4a. Facility Name (If not institution, give treet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ad MOY e 1 Under 24 Hrs. tue 7. Age (In yrs. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Gountry) **Funeral** 214-40-4593 Usual Residence of Decedent 1**X**M 2□ F Hours Director with the Maryland 10b. County 10a, State 10c. City, Town or Location or 28a-f show 10d. Inside City Limits rsi', or items 23a or 28a-f shov Exemployr must be notified at Maryland 10e. Street and Number Directo 1 XYes 2 No mor 10f. Zip Code 10g. Citizen of What Country? 212 521 50n Funeral death Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: It Item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Errections once. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ucator Dalto. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Stavus 2 uman rance 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Typg, Print) 2 man 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition -Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/27/2006 Mem. Park 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P.A. Funeral Home, r.n., De. Balto, Md. 21216 ph Li Russ tu Enter the disease, or complications that cause, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** infection disease or condition resulting in death) Dehydration £(/Medical Due to (or as a consequence of): Examiner NONTS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The faw requires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit Due to (or as a consequence of) of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) Dav Year 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Completed 1 Yes 2 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: To the Funers! Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation Injury death. 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 Homicide within 24 hours of To the Funers! To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) HENDING-MA 20, 2006 o co pleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

12 32. Registrar's Signature



			1 - For State Registrar	State of M	arylan		artment tificate			ınd M		giene, Reg. No.	2006	198	395					
	Physici /Medio		Decedent's Name (First, Middle, La Leonard Pf	arr							2. Date of Dea Month June	2 ^{Day}	20 06	3. Time of 0	Death 50aM					
	4a. Facility Name (If not institution, give street and number) Gilchrist Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda					land historia.	4b. City, Town, or Location of Death TOWSON					4c. County of Death Baltimore								
D.	uneral irector		216-34-2078 Usual Residence of Decedent	Sex 7. Ag	68	Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birti Month, Day OCL. I	0 , 1 9	9. Birti 9. Birti Mar							
the Maryla	28a-f shov rotified at	rector	10a. State 10b. County Balti	more	10c. Cit	y, Town or Lo Balt						10g Citiz	en of What Co	10d. Inside City 1 ☐ Yes						
death with	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Practically is marked other then "naturely or flems 23s or 28s-f show eny injury or other treumatic event, the Medical Examinat must be notified at ODGs.	by Funeral Director	3621 Melanie	12. Was Decedent	Ever in U	.S. 13. V	2 Was Deced	123	spanic Orio	in? (Spe	cify Yes or No-	USA	4. Race - Amer	ican Indian,						
0036 hours after	urel', or its al Examina	d by Fu	1 Wever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 If Yes, Give Year or Dates:			Yes, spec	X No	Specify:	, Puerto F	Hican, etc.)		Black, White Specify: Wh	ite						
Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland the and mental Hydiene.	or then 'ne' the Medic	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th	College (1-4or	5+)	16a. Deced (Give life. L Driv	kind of wor DO NOT us	l Occupa k done d e retired)	tion u <i>ring</i> most	of workin	ng .	16b. Kin	d of Business/I	ndustry						
aryland should be file	varked oth	To Be (17. Father's Name (First, Middle, Last, Phillip Pfar	r Sr.					V:	irgi	(First, Middle, .nia Le	ewis								
e, Mar 1 and 2 sh tealth and	ım 27 is n her treun		19a. Informant's Name/Relationship (Daniel Hennem 20a. Method of Disposition			362	1 Me	lan:		oad	Route Number Baltir	nore	MD							
Baltimore, permit. Pages 1 ar Department of Hea	rtant: If Ite njury or of		1 Burial 2 Cermation 3 4 Donation 5 Other (Specifical Signature of Funeral Service Liceral)	(y)	Ba	Hace of Disposemetery, crem	cre:	mate		6/22	2/06	Balt	ation - City or 1 Limore	MD						
Balt permit.	eny l		1 R. Tur	y (on	nel	ly o	. Name and	elly	Fun	era.	l Home	of		to. MD 21221						
/ /M Exa	sician edical miner	Jer.	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as	a consequ	uence of):		or dying	, 33317 23 0		respiratory air			Approximate Interval Betwee Onset and De	eath					
68760, C		Completed by Physician/Medical Examir	edicai Examiner	dicai	dicai	dicai	dicai	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	uence of):									
.O. Box (IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3 🗆	Ectopic pre Other (spe					23	d. Date of deliv	ery Day Ye	ear .					
ords, P.			Completed by	Completed by	Part II. Other significant conditions o	ontributing to death b	ut not resu	ulting in the un	derlying ca	use giver	n in Part I.		23e. Did tot			the cause of dea				
rhe law						25. Was case referred to medical	V							24a. Was a autops perform	No No	death?	opsy findings avorabletion of cau	vailable use of		
of Vita Physician:	s cert	o Be	examiner?	Hospital:	not 2 🗆	ER/Outpatient	3□ DOA	Other			Check only on e 5 ☐ Reside		fan is	100 500	10					
VISION Of Attending Phy r death.	After th	ation; To		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		c. Injury a		28	Bd. Describe ho			m nospic	4				
DIVIS	iral Director: iled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)								City or Town	n (Street and Number or Rural Route Number, Town, State)								
To the Hospital o	To the Funaral Dir completely filled in	Medicai	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam 29b. Signature and title of certifier	ysician: To the best niner: On the basis of and manner sta	i examınat	wledge, death ion and/or inv	estigation, i	n my opi	nion, death	place, an	d at the time, da	ate and p	lace, and due t	o the cause(s)						
To	- Mill Pino		Man	lung		00.1		D S		3	nune	J V N	signed (Month,	Lay, Year)						
	\ C10		30. Name and address of person who AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	completed cause of d	460	(1/,	(Nov	les	St	BAL	nune	m	21204							
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Amend item 9 per fly 8856 6-23-06 vt.

			1 - State Registrar		artment of Health and N tificate of Death	lental Hygie Reg.	0000	19896							
ı	Physici		Decedent's Name (First, Middle, Last) Odell Palmer	2. Date of Death Month	Day Year	3. Time of Death 3:04am M									
1	/Medic Examir		4a. Fecility Name (If not institution, give street and		4b. City, Town, or Location of Death	June 18,	4c. County of Death								
			Washington Adventist 5. Social Security Number 6. Sex,	Hospital 7. Age (In yrs. last birthday)	Tacoma Park If Under 1 Year If Under 24 Hrs.	9. Data of Birth	Montgome								
L	Funeral Director		225-52-4122 17 SM 2		Months Days Hours Min.	Japonth, Day, Ye Teb. 26, 1	.941 Danv	lace (State or Foreign try) ville, VA							
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		10	0d. Inside City Limits							
	Ba-fet	sctor	MD Prince Georg	es Hyatt	sville			1 Yes 2 □ No							
	3a or 2	i Dire	10e. Street and Number 4922 Lasalle Road		10f. Zip Code 20782		Citizen of What Coun	try?							
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental hygiene. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinal must be notified at once.	d by Funeral Director	1 Never Married 2 Married 1 Yes	es 2 No	Was Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerlo ☐ Yes 2月 No Specify:		14. Race - America Black, White, e Specify: B13	etc.							
15-(in 72 h	ojetec	15. Decedent's Education (Specify only highest grade comple	ted) (Give I	ent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	. Kind of Business/Ind								
	filed within Hygiene. Other than "gent, the Med	Completed by	Elementary/Secondary (0-12) Colle	tile Worker	T	extile Ind	ustry								
Maryland	ould be file Mental Hy arked oth	Be	18. Mother's Name (First, Middle, Maiden Surname)												
aryl	2 should and Men ie marke aumatic	ြင	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or Rura		ity or Town, State, Zip	Code)						
	1 and 2 Heelth em 27 i		Carol Wallace / Niece	10: 20b. Place of Dispos		nville, VA									
Baltimore,	permit. Pages 1 and 3 Depertment of Heelth Important: If Item 27 eny injury or other tr once.				1 Burial 2 Cremation 3 Removal fi 4 Donation 5 Other (Specify)	rom State Highland B	urial Park June 2 2000	23, _	Location - City or Tov Enville, VA	wn, State					
Bal	Depentition Depentition Depentition Depentition Depentition Depentition Depentition Depending Depentition Depending Dependeng Depending Depending Depending Depending Depending Depending		21. Signature of Fury ral Service Licensee	1 (Name and Address of Facility Charles L. Stevens FU 1501 Fast Fort Ave Ba	VERAL Home I	inc. 21230								
	Pnysician /Medical Examiner	er						Approximate Interval Between Onset and Death							
68760,	tificate be executed g physicien and as the burial-transit	by Physician/Medicai	by Physician/Medicai	by Physician/M	by Physician/Medicai	by Physician/Medicai	by Physician/Medicai	by Physician/Medicai	Sequentially list conditions, if any leading to amount of august Enter Underlying Cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last Due d	Sepsitive to (or as a consequence of): $2 SPD$	on HB				
P.O. Box 6	The law requires thet the death certifi sie has been signed by the attending page 2 should be detached for use as								in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year	
	w requires thei been signed t should be det								þ	ρ	Part II. Other significant conditions contributing	o death but not resulting in the uni	derlying cause given in Part I.		co use contribute to the
Vital Records,	ician: The iaw re certificete has be rector, page 2 sho	Completed	Of Manager			24a. Was an autopsy performed 1 Yes 2	prior to com death?	sy findings available pletion of cause of							
f Vii	A SE	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital:	Inpatient 2 ☐ ER/Outpatient	26. Place of Death 3 DOA Other: 4 Nursing Hor		6 □Other (Specify)								
Division of	inding ath. r: After									2 Accident investigation	ate of Injury Month, Day Year) 28b. Time of Injury		28d. Describe how in		
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Certification:	3 Suicide 6 Could not be determined 28e. P	et, factory, office 2	281. Location (Street and Number or Rural Route Number, City or Town, State)										
	ne Hosp n 24 hou ne Fune detely fil	Medical	Check only 2 Medical examiner: On the	the best of my knowledge, death te basis of examination and/or inven- nanner stated.	occurred at the time, date and place, a satigation, in my opinion, death occurre	and due to the cause ad at the time, date a	(s) and manner as sta and place, and due to t	ted. he cause(s)							
	To the within 2 To the complex	Ň	29b. Signature and title of certifier		29c. License number D 0 0 6 0 1 0 U		Date signed (Month, D	ey, Year)							
2			30. Name and address of person who completed of	ause of death (Item 23a) (Type, P											
	Sta	te 1	31. Date filed (Month, Day, Year) 3:	2. Rehistrar's Signature	and for TACO	MA VAR	Kmo 2	12712							
	Registra		JUN 2 3 2006	Some H A	and a										

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 13, 2006 6:45 AM June Vivian Riggs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Prince Georges Southern Maryland Hospital 8. Date of Birth (Month, Day, Year)
Dec. 23, 1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 TF 1925 Oklahoma Director 80 446-16-3783 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other then "naturel", or items 23s or 28s-f showent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Clinton Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20735 7908 Eaton Lane Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: ۾ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Government permit. Peges 1 and 2 should be filed v. Department of Heelth and Mental Hygie. Important: if Item 27 is marked other tt eny injury or other treumatic event. It page. Cartographer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Irene Williman Gilbert W. Light 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 212 Hannes St., Silver Spring, MD Rowena DeLuca Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 15,2006 Clinton, Maryland Lee Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. D. Silles M01284 6633 Old Alexandria Ferry Rd., Clinton, MD 20735 runta 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final angh eno **Physician** disease or condition resulting in death) /Medical to (or as consequence of): intra abdomina Examiner MOMATO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner TICSHO The law requires that the death certificate be executed ettending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. δ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 2 No 1 Yes Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 1 Impalient 1 🗌 Yes 2 ER/Outpatient 3□ DOA ٩ this within 24 hours efter death.

To the Funerel Director: After thi
completely filled in by the funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date stoned (Month Day, Year 29b. Sign and title of certifie 23a) (Type, Print) who completed cause of death (Item Date liled (Month, Day, Year)
JUN 2 3 2006 Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien [] [Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Walter Leroy Roth June 17, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford 6. Sex 1 ፟ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Director 219-16-4759 July 24, 1923 82 Maryland Usuaf Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or iteme 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1705 Parkview Road USA death 21047 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ģ Specify. 3 Widowed 4 Divorced WW II White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 te marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Line Worker Box Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward (u/k) Roth Emma (u/k) Hartline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 te any injury or other trau once. 1705 Parkview Road, Fallston, Maryland 21047
ace of Disposition (Name of Date 20c. Location - City or Town, State Marian E. Roth - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 \(\mathbb{R}\) Burial 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Removal from State} \) 4 \(\subseteq \text{Donation} \) 5 \(\subseteq \text{Other} \((Specify) \) Oak Lawn Cem. 6/21/06 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause or each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocurulal **Physician** Cute /Medical Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physicien and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ this certificete has been signi al director, page 2 should be 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2X ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending М 1 TYes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D34652 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) North Avenue Bil Air Scott 1745W11 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature JUN 2 3 2006 Registrar

DHMH 17 Rev 1/2001

Maco 100018

Koth, Walter

06-04199 George Stanford

Please Type or Print in Black Indelible Ink
State of Marvland / Department of Health and Mental Hydiene

		1- For State 1- For State Certificate of Death Reg. No.	1989
Physici Medical Exami		1. Decedent's Name (first, Middle, Last) 2. Date of Death Month Day Year	me of Death
7		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death	656 hrs
⊂ Funeral		Union Memorial Hospital 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24Hrs 18. Date of Birth/MM/IDD/YYYY 9. Birtholacu	
Director		3. Social security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace Months Days Hours Min. 1 9 - 1	e (State or
any		Usual Residence of Decedent 10a State 10b County	17191
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sho and 7 is	٦ م	19a Informant' Jame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber, City or Town, State, Zip Columber of Rural Route Number, City or Town, State, Zip Columber, City or Town, State, Zip C	
_ 2 8 8 8		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, crematory or other place)	
Baltimore, permit. Pages 1 a Department of He mportant: If ite		4 Donation 5 Other Specify: MT. Zum 6-22-06 Cansdowne	
Derm Depa Import		Much M. Teplace Dana military 5	21229 eto, md.
Physician /Medical		25a. Part Detrier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart left only one cause on each line. Appropriate the mode of dying, such as cardiac or respiratory arrest, shock, or heart left only one cause on each line.	roximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiac amyloidosis associated with cardiomegaly Due to (or as a consequence of).	Death
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	Examiner	cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of).	
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Division of Vital Records, ral or Attending Physician: The law require is after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a page 3 should be a page 3 should be	E O	autopsy prior to completic performed? death? 1 ✓ Yes 2 N 1 ✓ Yes	on of cause of
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To the within To the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(and manner stated.	
	_	29c. License number 29d. Date signed (Month, Day, O.C.M.E. June 18, 2006	year)
	ŀ	30. Name and address of person who completed cause of death (Item 23a)	
Sta	ite	and the state of t	
Registr	ar	31. Date filed (Month, Day, Year) 33 Registrar's Signature 4 Aparts	

Kenneth Joseph Smialkowski

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 19900

		Registrar	Cer	tificate of	Death			Reg. No.	000 1330
Physicia		Decedent's Name (First, Middle,Last)					Date of D Month	eath Day Yea	3. Time of Death
Medical Exami	ner	Kenneth Joseph	5	Smialko	wski		June 16		2255 hrs
man.		4a. Facility Name (if not institution, give street and numb	er)		4b. City, Town, o	r Location o	f Death	4c. County	of Death
		Johns Hopkins-Bayview		1	Baltimore				
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	g Address (Stre		ber or Rural Route N	lumber. City or Tow	n. State. Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f short or other traumatic event, the Medical Examiner, must be notified at once		Edward Smialkowski brot	her	1			e, Essex,		
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Baltimore, permit. Pages I at Department of He Important: If ite		21 Signature of Funeral Service Lio nite	111	22. N	lame and Addres	s of Facility	1 Home Of	Dundalk	РΑ
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	ē	if any, leading to immediate Due to (or as a co cause. Enter Underlying Cause	nsequence of	r):					
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<u>1200</u> 0	Σ	29b. Signature and title of certifier				ise number		29d. Date signe	ed (Month, Day, Year)
		web			0.0	.M.E.		June 17, 20	006
		30. Name and address of person who completed cause of	f death (Item	23a)					
0		Ana Rubio MD. Assistant Medical Ex	aminer '	111 Penn S	Street, Baltim	ore, MD	21201		
S	tate		rar's Signatu	re			<u> </u>	· · · · · · · · · · · · · · · · · · ·	
Regis		JUN 2 3 2006 Beau		K And	all I				
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				For State of Ma	ryland /		artment of F tificate of		Mental Hy		6001	19901
				Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate of	Dealli	2. Date of D	Reg. No	0.	3. Time of Death
		Physici							Month	Da 10	•	
		/Medio Examir		Geraldine E. Sears 4a. Facility Name (If not institution, give street and number)			4b. City, Town, o	r Location of De	06		9 200 c. County of De	
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2		Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last	birthday)	If Under 1 Year Months Days		rs. 8 Date of Bi	irth	0.8	rthplace (State or Foreign Country)
9		Director		201 – 18–2032 ^{1□ M 2} ₩ F	83	Yrs.			n. (Month, D) 12/12/	1922	2 Pei	nnsylvania
		and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside City Limits
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0		28a-	Director	10e. Street and Number	KIIIC	svil	10f. Zip Code			10g. C	itizen of What C	Country?
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3	b	illed i Hyg other	Be C	17. Father's Name (First, Middle, Last)		010.	L J L	18. Mother's N	ame (First, Middle			**
0	<u>lar</u>	Jid be Aenta Aenta riked tic ev	To B	Jerry C. Thomas				Viole	t Fitzge	rald	E	
4	Maryland	sholl and help ma		19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailín	g Address (Street	and Number or I	Rural Route Numb	er, City	or Town, State,	Zip Code)
a	Σ,	and 2 ealth n 27		Edward D. Sears (husband)				alem Roa				ryland 21087
3	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", any fujury or other traumatic event, ins M-alicul Exagnee.		20a. Method of Disposition 1	20b. Place ceme	of Dispo tery, cren	sition (Name of natory or other plac	ов)	Date	20c. L	ocation - City o	r Town, State
1	tim	tment: tant:		* 4 ☐ Donation 5 ☐ Other (Specify)	St. P	aul'	s Luth, (Cem. 06	/23/2006	Kir	gsville	, Maryland
0	Bal	Depar Mpor mpor uny Irr		21. Signature of Funeral Service Licensee								al Home, P.A.
B		202 4 4		23a. Part1. Enter the disease, or complications that caused	the death . F						le, Mary	land 21087
				shock, or heart failure. List only one cause on each lin	e.	o not ent	of the mode of dyli	ig, such as cardi	ac or respiratory a	irresi,		Approximate Interval Between Onset and Death
		Prysician /Medical		disease or condition resulting in death)	tatie	_ (hest Su	roma				few month
	P	Examiner		Due to (or as a	consequenc	2 0 01):						1900
			Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a green and a sequential by the sequential between the sequential by the sequentia	consequenc	e of):						
1		cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
	, 0,	e exe		resulting in death) Last Due to (or as a	consequenc	e of):						
5	68760	ficate be executed physician and s the burial-transit	edicai	d								
ear	_	- CD et		IF FEMALE: 23c. If yes, outcome of	of pregnancy						201 5	
S	Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	in the past 12 months?	2 Fetal dea		Ectopic pregnancy Other (specify)	,			23d. Date of de Month	Day Year
0 3	P.0.	the d by the	nysi	1 Yes 2 No 9 Unknown				-				
F	σ,	s that ned t	by P	Part II. Other significant conditions contributing to death but	t not resultin	g in the ur	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
3	rds	w require been sig should b							1 🗆	Yes 2	No 3 □ P	robably 4 Unknown
Th	Division of Vital Records,	e law re has be je 2 sho	Completed						24a. Was		24b. Were a	utopsy findings available
	Ä	The ate his page	mo:							ormed?		completion of cause of
0	/ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					eath (Check only			
5	of \	hysio this c	၉	1 Yes 2 No Hospital: 1 Inpatier				4 Nursing	Home 5 ☐ Resi			ecify)
garaldine	n c	Attanding Physician: r death. ector: After this certifica by the funeral director. I	ion	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injuny (Month, Day)	Year) 28t	. Time of Injury	28c, Injun Work	yat k? Yes 2 □ No	28d. Describe	how inju	ry occurred	
270	Sic	vttandi death. ctor: A y the fu	lical	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Inju	rv - At home.	farm stre		163 2 110	28f. Location (Street ar	nd Number or F	ural Route Number.
3	Div	after after Direct	Certification:	4 Homicide determined building, etc.	(Specify)		ot, tadiory, onloo		City or To	wn, State	9)	order roote roomber,
		Hospital or the hours afte Funaral Dir tely filled in		29a. Certifying Physician: To the best o	f my knowled	lge, death	occurred at the tin	ne, date and place	ce, and due to the	cause(s) and manner a	s stated.
		To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only one) 2 Medical Examiner: On the basis of and manner state	examination ed.	and/or inv	estigation, in my o	pinion, death occ	curred at the time,	date and	d place, and du	e to the cause(s)
		To the To the Comp	Σ	29b. Signature and title of certifier	MO		29c. Licens		2		ite signed (Mon	
	•			Mancher broke	11/		1/-	500 40	/	0	76-20-	1006
		1-		30. Name and address of person who completed cause of de					11 100	10	17 1	W 7 7 1 1 1
		() Sto		31. Date filed (Month, Day, Year) 32 Registra	r's Signature	1/6/25	S CENTE.	IL WAY	#1021	6:16	tWOOD)	111/11040
		Sta Registr		IIIN 2.3 2006	, At	600	was		#102,			
			-	TOTAL COOL NEW YORK	-	-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Robert Edward Thompson 9:48 Рм June 13, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1939 Months Days Hours Min 1⊠M 2□F 67 Yrs. Washington, D.C. 212-36-2077 6, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other treumatic event, Ira Modical Examinar must be notified at once. 1 ☐ Yes 2 X No Rockville Maryland Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20853 13001 Vandalia Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Commercial Elementary/Secondary (0-12) Coltege (1-4or 5+) Coffee Company Service Manager 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (not available) Emily Clarence Thompson ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13001 Vandalia Drive, Rockville, Maryland 20853 Greta D. Thompson/Wife 20b. Place of Disposition (Name of June 20, 20c. Location - City or Town, State 20a. Method of Disposition commetery, crematory or other pla Montgomery Crematorium, Inc. crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2006 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Peripheral Vascular Disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit pue resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, the ettending physicien Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No been signed by the should be detached 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Renal Failure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Liver Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hes page 2 1 ☐ Yes 2 ☐ No 2⊠No certificate 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ♣ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 3 DOA this 24 hours efter death.

• Funerel Director: After thiselv filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division Injury 1 Naturat 5 Pending 1 Yes 2 No investigation 2 Accident within 24 hours efter dea To the Funerel Director completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide Hospitai 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DOCGUG 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Dr Stu 105 9715 Frederick Beivers 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rag. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Washington, Jr. James 2006 6 20 8:10a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Millersville Knollwood Manor If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Director 9-22-23 S.C. 82 251-28-6316 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. importent: if item 27 is marked other than "naturel", or items 23s or 28s-f ehow with jury or other traumatic event, the Madical Examiner risual be nutified at once. 1 XYes 2 No Director N.J. NA Willingboro 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 08046 USA 61 Windsor Lane by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 🔀 No ff Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Black Specify: 3 ☑ Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) City of Newark Water & Sewage 8th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Washington, Sr. 2 James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 713 Chapel Gate Dr., Odenton, Md. Granddaughter Renee Washington 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairmount Cem. 6-26-06 Newark, N.J. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 lade Women March F.H. East 1101 E. North Ave. Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition HTHEROSCLEROTIC **Physician** CARDIOVAS CULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, ed by the ettending physicien detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à pe 45 PASTIC 1 Yes 2 No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No EREBROVASCULAR 24a, Was an certificate has autopsy performed 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 1x Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ş. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD 005 20. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink

5

erry E. Walker, c	1	State of Maryland / Department of Health and Mental H		g. No. 201	06 1990
Physiciai Iedical Examin	n/	Registrar 1. Decedent's Name (First, Middle, Last) ERRY Edward Walker DR.	2. Date of Death Month June 9, 20	n Day Year	3. Time of Death 1825 hrs
Funeral Director		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min.	8. Date of Birtl	4c. County of Dea A)A n(MM/DD/YYYY) 9 E Fore bel 71967	Birthplace (State or
16 n 72 hours after death with nan "natural", or items 23 lival Examiner must be no	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1344-fmo Re 10f. Zip Code 10f. Zip Code 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 12. Married 13. Widowed 14. Divorced If Yes, Sive Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of voluming most of working life. DO NOT use retired than the status of working life. Do NoT use retired than the status of working life. Do NoT use retired than the status of working life.	vork done red) (First, Middle, M	14. Race - Ame White, etc. Specify: Al 16b. Kind of Business	10d Inside City Limits 1 XYes 2 No nuntry? erican Indian, Black, FIGAL AMERICA S/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than 'injury or other traumatic event, the Medical		Address of Facility Address of Facility Address of Facility An exp m. Waccace 34051(cv) Facility Franckless	BAHMA Date e36,2006 Funeru St-BA	catonsuice	nd 2/206 or Town, State le Manyland
	aminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Choking on a foreign body complicated by a mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	r respiratory arre: cocaine	st, shock, or heart	pproximate Interval Between Onset and Death
Box 68760, te death certificate be executive at the attending physician and the for use as the burial - tra	hysician/	JUNPENDED AMENDED item#23a.PIT.27.28a—f.perME.g858.8/2 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions AMENDED item#23a.PIT.27.28a—f.perME.g858.8/2 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify) 9 Unknown	ncy	23d Date of delive Month account of the live of the	Day Year
Vital Records, P.O. ysician: The law requires that the law requires that the law requires that the last certificate has been signed by director, page 2 should be detact	Completed by	Left ventricular hypertrophy 25. Was case referred to medical 26. Place of Death (Check of D	1 Yes 24a. Was an autops perform 1 Yes 2 ponly one)	n 24b. Were a y prior to ned? death?	
Division of Vital Records, pital or Attending Physician: The law require ours after death reral Director: After this certificate has been sifiled in by the funeral director, page 2 should be a shoul	ertification: To Be	27. Manner of Death 1 Natural 5 Pending 2 X Accident Investigation 3 Suicide 6 Could not be 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Ves 2 No 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28d Describe ho Subject of end of pol 28f. Location (St or Town, Sta	ice chase reet and Number or Rate) 1704 N. W	reign body at
Divisior To the Hospital or Attent within 24 hours after death To the Fineral Director: completely filled in by the	Medical Cer	4 Homicide determined (Specify) Roadway 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.		(s) and manner as sta	
F 3 F 8	Me	29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who complete dause of death (Item 23a)		29d. Date signed (M. June 10, 2006	onth, Day,Year)
Sta Registr	L	Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2 31. Date filed (Month, Day, Year) 11. Registrar's Signature	1201		······································

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Yeer **Physician** Jeannelle June 8:30 pm 2006 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner glonsul If Under 24 Hrs. timore Nursing + Kehab trederick Villa If Under 1 Year Birlhplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months Hours 1 □ M 2€XF MARYLAND Director 218-28-5559 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 💢 No Director MARYLAND BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 4712 OLD COURT RD by Funeral 21208 .A. 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 X Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY CLERICAL 12th grade ADMINISTRATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ERNESTINE WATKINS RAYMOND WATKINS 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Phillip Williams Sr./Son 4712 Old Court Rd., Baltimore, Maryland 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMOIRAL PARK 06-23-06 BALTIMORE, MARYLAND WITH TAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signat of Funeral Service Licensee 1206 W NORTH AVENUE and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 45cm ar Examiner Due to (or as a consequence of) Examiner Hospital or Attending Physician: Tha law requires that the death certificate be executed usa as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician end for usa as the burial-tran Division of Vital Records, P.O. Box 68760, edical Certification; To Be Completed by Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this cartificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No ours after death.

oral Director: After this cartificatilled in by tha funeral director, it 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 T Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the To the 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier D47683 6/21/06 Payment Mulis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P Raymone Miller Reintestown Street Sinte Main 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

JUN 2 3 2006

			For State Registrar	State of N	Marylan				ealth a Death	nd M	-	giene Reg. No.	200	16	1990	7
			Decedent's Name (First, Middle, La	st)							2. Date of Da	ath			3. Time of Death	—
	Physici /Medio		Frank Lewis Wlad	kowski							Month June	21 Day	200	ear Ó	8:15a	М
>	Examir		4a. Facility Name (If not institution, giv	e street and number	r)		4b. City,	Town, or	Location of				County of		1 3 7 2 3 2	
1			Gilchrist Hospi	ce			Tows	son				Ba	altim	ore		
	Funeral		5. Social Security Number 6. S		Age (In yrs. I	•	If Unde Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	h v. Year)	9	Birthp	lace (State or Forei	gn
	Director		210 30 4733	X M 2□F 6	7	Yrs.					March 2			MD_		
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City	/. Town or Lo	cation							1	0d. Inside City Limit	te
	Aaryli Feho	ᡖ	MD Carroll		3	Sykesv	ille								1 ☐ Yes 2 🛣 N	
	28a-	ect	10e. Street and Number		_1		10f Zir	Code				10g Citi:	zen of Wh	at Cour	ntry?	_
	with sa or	Funeral Director	6611 Sweet Air La	ne				784					JSA	u. 00u.	, .	
	heath me 23	era	11. Marital Status	12. Was Decede		S. 13. 1	Was Dece	dent of Hi	spanic Orig	in? (Spe	city Yes or No	- 1	4. Race -	Americ	an Indian,	
(0	fler	Fun	1 ☐ Never Married 2 ☐ X Married	Armed Force	No		fYes, spe	cify Cuba	n, Mexican,	Puèrto F	Rican, etc.)		Black,	White,	etc.	
93	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give / Year or Date:			1 🗆 Yes	2LXNo	Specity:				Specify:	whi	te	
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gra			16a. Dece	dent's Usu	al Occupa	ation	of workin	20	16b. Kir	nd of Busin	ness/In	dustry	_
21	thin thin	npie	Elementary/Secondary (0-12)	College (1-4c	r 5+)			se retired	luring most)	0, 40,747	·9					
7	ygien ygien ver th	ပ်	12			anal	yst						ernme	nt		
pu	d off	To Be	17. Father's Name (First, Middle, Last) Frank Wladkowski)					18. Mother Anna		(First, Middle,	Maiden	Sumame)			
yla	ould Men Merke Marke	ဥ														
Maryland	2 sh 2 and 3 and 1 is m		19a. Informant's Name/Relationship (Ann Wladkowski (Route Number				Code)	
	l and leeith		20a. Method of Disposition		20h BI	lace of Dispo			 ,		ate					_
0	# It of H		1 TyBurial 2 Cremation 3	Removal from Sta	te Cé	emetery, crer	natory or o	other place					cation - Ci	•		
ţ	t. Pa tmer rtent		4 □Donation 5 □ Other (Specif	·	OTq	Holy		•		- 24 -					n, Md	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itame 23s or 28s-f show any Injury or other treumatic event, the Medical Exam armust be motified at once		21. Signature of Funeral Service Licer Daige Haight			P.	O. Bo	nd Addres	s of Facility 5 Syk	Haig esvi	ht Fune 11e, Mo	eral 1 217	Home 784	& (Chape1	
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	ed the death line.	. Do not ent	er the mod	de of dying	g, such as c	ardiac or	respiratory ar	rest,			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	· m	etas to	tile	Co(0	u a	ance					(12)	Onset and Death	
4	/Medical		resulting in death)	Due to (or a	as a consequ	ience of):									1	
н	Examiner		Sequentially list conditions,	b												
-	/g =	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dus to (or s	upe enos a ea	refice of).										
7	ecute and trans	Examin	that initiated events resulting in death) Last	C. Due to for						<u></u>						_
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8760,	cate be executed physicien and the burial-transit	dicai		d										-	- C	_
9	The law requires that the death certific site has been signed by the attending rage 2 should be detached for use as	0 1	IF FEMALE:	23c. If yes, outcon	o of program	201										
Box	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal	death 3	Ectopic p					2	3d. Date o Month		ry Day Year	
-	he de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		ain 5	Other (sp	өспу)								
P.O.	thet t ed by detai		Part II. Other significant conditions of	ontributing to death	but not resu	ilting in the u	nderlying	ause give	n in Part I.		23e. Did to	bacco us	e contribu	ute to th	e cause of death?	
ds	uires Sign	d by									1 🗆 Y	es 2	ZNO 31	□ Prob	ably 4 □Unknow	n
Ö	w requir been si should I	ete							-		04- 145-	/	0.45 144-			
Records,	has ge 2	Completed								_	24a. Was autop	sy	prio dea	r to cor	osy findings available apletion of cause of	В
<u>a</u>			25. Was case referred to medical								1 ☐ Yes	2 No	1 🗆	Yes	2□ No	
₹	Physician: this certifice ral director.	o Be	examiner? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	Hospital:	·· 201			Othe			(Check only or		chi a		[a - a - a]=	
Division of Vital	Phys r this sral dii	: To	27. Manner of Death	1 ☐ Inpa	jury	ER/Outpatien 28b. Time of		M	4 🗆 Nurs		e 5 ☐ Resid 8d. Describe h			Specify	Mospice	
O	th. After funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, L	Say Year)	Injury	м	8c. Injury Work 1 □ Y	? ′es 2 □ N							
/isi	Attending in death.	fica	3 Suicide 6 Could not b	e 28e. Place of	njury - At hor	me, farm, str	eet, factor	, office		2:	8f. Location (S	treet and	Number o	or Rura.	Route Number.	
á	after after d in b	Certification:	4 Homicide	building,	etc." (Specify,)					City or Tow	m, State)			,	
	spite nours nere		29a. Certifier 1 Certifying Ph	ysician: To the be	st of my knov	vledge, death	occurred	at the time	e, date and	place, ar	nd due to the o	ause(s)	and manne	er as st	ated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edicai	(Check only 2 Medical Exar	niner: On the basis and manner	of examinati stated.	ion and/or inv	estigation	, in my op	inion, death	occurre	d at the time, o	date and	place, and	due to	the cause(s)	
_	Within To the Comp	Σ	29b. Signature and title of certifier				290	. License	number		2	29d. Date	signed (A		Day, Year)	_
			> Juline	~ ~~				1)50	303			724	121	9	900	
	1		30. Name and address of person who	completed cause o	death (Item	23а) (Туре,	Print)	01	a - ~		12-0	2	(\ e \ \			
\			Afron CHARLES	, NO 66	101 N	· Cha	rux	7	17/17/17	MA	e m	416	4			
	Sta		31. Date filed (Month, Day, Year)	32 Regis	trar's Signat	ure							_			
	Registr	ar	JUN 2 3 201	10 1000	W 10	1400	1									

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Wladkowski, Frank

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 9:05 P M Wendolkowski Erika June 5. 2006 K1ara /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville National Lutheran Home If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months 1 ☐ M 2 🕱 F 81 Germany Director 055-30-2060 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "neturel", or items 23e or 28e-f show other traumatic event, the Medical Examinat must be notified at 1 ☐Yes 2 XNo Director Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20850 USA 9701 Veirs Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental t Freida Matiebel ဂ္ Otto Meyer 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Christina Franz/Daughter 226 South Bayview Avenue, Freeport, NY 11520 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Department of Importent: If any injury or Holy Rood Cemetery 6-10-06 Westbury, NY 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Krauss Funeral Home 21. Signature of Funeral Service/Licenses Hanna 1097 Hempsted Turnpike, Franklin Square, NY 6. Approximate Interval Between Onset and Deat or complications that caused the death. Dunot enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to annociate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed CON burial-tran Due to (or as a physician Physician/Medical the as attending IF FEMALE: esn esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🖾 No ō 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No certificate 2X No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 🗌 Yes 2⊠No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide To the Hospitel within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signaty and title of certifier arel ell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh, 26033 Ridge Road, Damascus, MD /20872 22. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 3 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. 1

Records,

Division of Vital

		1 - State Registrar	Department of Health and I Certificate of Death	Reg. No. 2005 19
Physici /Medi		1. Decedent's Name (First, Middle, Last) John Wroblewski		2. Date of Death Month Day 2006 2.46
Examir	ner	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 212–28–4402 7. By 2 F 79	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	
Maryland a-fehow	tor	10a. State 10b. County 10c. City, Tow	m or Location timore	10d. Inside City X☐Yes:
with the	i Direc	10e. Street and Number 3939 Roland Avenue Apt 519	10f. Zip Code 21 21 1	10g. Citizen of What Country? USA
within 72 hours after death with the Maryland ene. Then "naturel", or Items 23e or 28e-f ehow he Medical Execution most be codified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes ♣☐ No Specify:	Specify Yes or No- to Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
filed within 72 hor Hygiene. other then "natura ent, in Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of world) iffe. DO NOT use retired) Labor	16b. Kind of Business/Industry Southern States
id 2 should be filled th and Mental Hyg 27 is marked oths traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Konstanty Wroblewski	Anna S	me (First, Middle, Maiden Sumame) Staskiewicz
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Disportment of Heelth and Mental Hygiene. Instruction if Item 27 is marked other then "naturel; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination manter and injury.		Edward Wroblewski Brother 20a. Method of Disposition 1 Burial 20 Cremation 3 Bemoval from State 20b. Place of cemeter	8619 Dovedale Roa of Disposition (Name of pry, crematory or other place)	ad, Randallstown, MD 21133 Date 20c. Location - City or Town, State, Zip Code) Catonsville, Maryl
permit. P Departme Importan any injur	Property	21. Signatur Jot Funeral Service Licensee	_ ,	Funeral Home, Inc. 21211 Baltimore, Maryland
Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Due to (or as a consequence Cause) Due to (or as a co	My ocandral i	nfarctin (V
The law requires that the death certificete be executed at has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unkn		23d. Date of delivery Month Day Ye
quires thet the de n signed by the a uld be detached f	۵	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of de
sician: The law requir centificete has been si irector, page 2 should I	Completed	Rinal mass		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
Physician: this certifice al director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	utpatient 3 DOA Other: 4 Nursing H	ath (Check only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:		Injury Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Numb City or Town, State)
To the Hospital or Attend within 24 hours after death To the Euneral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge on the desired form one on the desired form one on the desired form one on the desired form one of the desired form one of the desired form one of the desired form on the desired form one of the desired form on the desired form on the desired form on the desired form on the desired form on the desired form on the desired form on the desired form of the desired form of the desired form on the desired form of the desired form on the desired form of the desire	nd/or investigation, in my opinion, death occu	urred at the time, date and place, and due to the cause(s)
To t To t	Σ	7 700	29c. License number D 314 6	29d. Date signed (Month, Day, Year)
5		30. Name and address of person who completed cause of death (Item 23a) SHOPIS A - HASHMI MD 821 31. Date filed (Mopth, Pay, Year) 33. Registrar's Signayure	(Type, Print) N. EUTAW ST Sh	ute 308 BALTIMIZE M
St Regist	ate rar	31. Date filed (Month, Day, Year) 33 Registrar's Signature	perte	

			1 = For State Registrar		Maryland		artmen rtificat					Reg. No.	2006	19910
	Physici	an	Decedent's Name (First, Middle CORNELIUS MI		r irni						2. Date of De Month	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution,				4b. City.	Town, or	Location	of Death	JUNE	17 4c. Co	2006 ounty of Death	6:15PM [™]
	Examir	ier	8352 LENNEP		,				MICHA				TALBOT	!
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. last	birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da April 2	th V Year	9. Birthp	lace (State or Foreign
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	ocation						1	0d. Inside City Limits
	Maryl f sho	Ď	Maryland Talb	ot		St.	Micha	aels						1 X Yes 2 □ No
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ž	should be nd Mental marked o	5	19a. Informant's Name/Relationsh			19h Maili	na Address	(Street o			McCart		own, State, Zip	Code
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Ē	Page nent o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		tate Park	clawn Par	matory or o Memo k	rial	.	June -2006		Rocky	ville, 1	Maryland
Baltimore,	permit. Pages in Department of Himportant: If ite any injury or ot once.		21. Signature of Funeral Service L	Licensee		22	2. Name an	d Addres	s of Facilit	ty	Eunoral	Цото	/Doolered	11a Tm.
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	21/		30. Name and address of person v	4 / /	en of death (Item 23			5.	TAU.	305	35 5	T. MK	14/06 CHAZI	s Au
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2	, E	gistrar's Signature	4 6	beech	,						

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	1 - State Registrar					Ce	rtificat	e of	Death	1		Reg	. No.		4 2	
	1. Decedent's Name	(First, Middi	le, Last)				2. Date o								3. Time of Death	
in ai			Isabe		Boswe	11 Wi	nner				June	1	9, 20	Year 06	7:00	РМ
er	4a. Facility Name (//	f not institution	n, give street and no	ımber)			4b. City,	Town, o	r Location	of Death			4c. County	of Death		
	Suburba	an Hosp	pital]	Beth	esda				Mont	gomer	У	
	5. Social Security N 213-32-6		6. Sex 1 ☐ M 2 🔯 F	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of (Month, June	Day, Y	^(ear) 1924	Cour	lace (State ontry)	r Foreign		
	Usual Residence of	Decedent		-			1					,				
	10a. Slate	10b. County		10c. City	y, Town or Lo	own or Location 10d. In							0d. Inside Ci	ty Limits		
ctor	Maryland	Montg	gomery		Rockv	ockville								1 M Yes 2 □ No		
<u>e</u>	10e. Sireel and Nur	nber					10f. Zip	Code				10g. Citizen of What Country?				
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Completed by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☒ Widowed	_	If Voc C	orces? 2 X N ive			Was Dece f Yes, spe 1 Yes	cify Cuba	ispanic Or an, Mexica Specify	n, Puerto	ecrly Yes or Rican, etc.)	No-		ce - Americ ck, White, v: Whi	etc.	3
etec	(Ѕрес		t's Education st grade completed,)		16a. Dece (Give	kind of wo	rk done d	during mos	st of work	ring		b. Kind of B		•	
dmc	Elementary/Seco	ndary (0-12)	College (1-4or 5	+)		nist:		,	ciet	ant		ontgon ublic		County	
ŏ	17. Father's Name (First, Middle, Last)							laci			e (First, Midd				010	
To Be	James Mo						Cecelia			16)						
_								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						Code)		
	Donna W.	Todd ,	/ Daughter	r							ardtown					
	20a. Method of Disp 1 ☐ Burial 2 [4 ☐ Donation	Cremation	3 □Removal from	State	C	lace of Dispo emetery, crer Mary 1	natory or c	ther plac		June 200			c. Location -	,	wn, State Mary	land
	21. Signature of Fu	Name ar	d Addres	s of Facili	Funer	al Home	/Ro	ckville	, Inc.							

Physician /Medical Examiner

Physici /Medic Examin

Funeral Director

ral', or items 23a or 28a-f ahow Examiner must be notified at

10

Examine Completed by Physician/Medical Medical Certification: To Be

M01305 300 West Montgomery Avenue, Rockvil

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 40 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy Year 4☐Pregnant at time of death 5 Other (specify)

in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. associated.

1 🔀 Inpatient

23e. Did tobacco use conInbute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes No 26. Place of Death (Check only one) Other:

24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes

25. Was case referred to medical examiner?

1 Yes 2 □ No 27. Manner of Dealh

1 Natural
2 Accident

3 Suicide

4 Homicide

5 Pending investigation

Hospital:

28b. Time of

2 ER/Outpatient

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred motor vehicle collision

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify,

street, factory, office

Location (Street and Number or Rural Route Number, City or Town, State) ROCKVILLE

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 DOA

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year) 2012006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 8600 Old Georgetown Road, Bethesda, Maryland 20814 Melissa Means-Markwell,

State Registrar

01

31. Date filed (Month, Day, Year) JUN 2 3 2006

6 ☐ Could not be determined



State of Maryland / Department of Health and Mental Hygiene 19912 1- State Registrar Amend #19a per/fh CNM 06-13 Contificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 John William . Angleberger June 5:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F Director 214-48-3908 63 Oct. 14, 1942 Maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic avant, the Medical Exarciner must be notified at 1 XYes 2 No Maryland| Frederick Frederick Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Itams 23a 1215 Rutledge Place 21703 В Apt. United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) rmit. Pages 1 and 2 should be filed within 72 hours after to partment of Health and Mental Hygiene.

ordant: If itam 27 is marked other than "natural" injury or other trainmain. Black, White, etc. 1 Never Married 2 Married ☐Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Maintenance Worker Iron / Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Angleberger Florence Bagent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Bedor / Sister 709 Motter Avenue Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State June 15, 2006 permit. Page Department Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Union Chapel Cemetery Libertytown, Maryland 21. Sign ture of Pyneral Cervice Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the discase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death AligNANI Immediate Cause (Final **Physician** Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate account Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? e Hospital or Attanding Pl 24 hours after death. a Funaral Diractor: After t 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral D 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0035152 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fredericik 180 . L. Krantz MD Thus Tohrlun 31. Date filed (Month. JUN 1 2 32. Resistrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene ? [] [] [Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician June 9, 2006 7:15 A Josephine K. Asendorf /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ellicott City 2937 Southview Road If Under 1 Year | If Under 24 Months Days Hours 8. Date of Birth (Month, Day, Year) Aug 31, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F Yrs Maryland 85 Director 214 14 5016 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 21042 United States 2937 Southview Road 238 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐No Specify. Specify: þ 3 Widowed 4 □ Divorced White "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 if Health and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Aurelia Shriver Frank Kane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2937 Southview Road Ellicott City, MD 21042 Richard H. Asendorf/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Importent: If ite 1 Burial 2 Cremation 3 Removal from State *4 □Donation 5 □ Other (Specify) Loudon Park Cemetery 6-13-2006 Baltimore, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pk. Ellicott City, MD 21043 M01442 Kald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Concer unknown Priman netristatic Physician 2 mas /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 2/2 No 1 Yes 2 🗌 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospitel 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 9,2006 person who completed cause of death (Item 23a) (Type, Print) Rd atmov/le 32. Regerar's Signature 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1	State of Maryland / Dep I - State Registrer AMEND # 23 Part PER PHYS CCHD 6-12-06 DB Ce			2005	19914
			1. Decedent's Name (First, Middle, Last)	Timodio of Dodin	2. Date of Death		3. Time of Death
	Physicia		Nettie W. Anderson		June 7, 2	Day Year	8:25 P M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Genesis Elder Care	La Plata H Under 1 Year H Under 24 Hrs.	9 Date of Righ	Charles	place (State or Foreign
П	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2X F 7. Age (In yrs. last birthday 95 Yrs.	Months Days Hours Min.	March 22	. 1911 Nor	place (State or Foreign ntry) th Carolina
			Usual Residence of Decedent				
	nylan how		10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2X No
	16 Ma	Directo		okeek 10f. Zip Code	100	. Citizen of What Cour	
	with the	급	10e. Street and Number		109	_	,
	ne 23	Funeral	14409 Livingston Road 11. Marital Slatus 12. Was Decedent Ever in U.S. 13	20607 Was Decedent of Hispanic Origin? (Sp. 18 Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Americ	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic avant, the Modical Examinal must be notified at once.		Armed Forces? 1 Never Married 2 Married In Yes 2 No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	Hican, etc.)	Black, White,	hite
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alii.	permit. F Depertm Importat any injui			22. Name and Address of Facility		d Washingt	
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Вох	death certific e ettending p od for use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	. ,
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Vital	sician: Th certificete rector, pag	0	25. Was case referred to medical	26. Place of Dea	th (Check only one		
of V	S .2 B	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat			nce 6 Other (Special	fy)
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Division	Attending r death.	licat	2 Accident investigation 3 Suicide 6 Could not be determined			eet and Number or Rui	al Route Number,
ĕ	after after Dira d in b	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attendir within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical (29a. Certifier (Check out) one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred	e, and due to the cau irred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	within 2 To the	Med	one) and manner stated. 29b. Signature and title of Pertifier	29c. License number	29	d. Date signed (Month	/Day, Year)
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2	7 - 4		30. Name and address of person who completed cause of death (Item 23a) (Type			-/-/-	-
1	XX.		Dr. Fatima Hussain, 5625 Allentown 31. Date liled (Month, Day, Year) 32. Jegistrar's Signature		prings, l	MD 20/46	
	St Regist	ate rar	31. Date liled (Month, Day, Year) 32. Jegistrar's Signature	parte			

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle Last) Month **Physician** Minnie Ackerman Ida /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Autumn Assiisted Living Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 30, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗙 F Kentucky 578-30-5050 78 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylanen of Health and Mental Hygiene.
sent: if items 22 is marked other than 'nature', or items 23s or 28s-1 show and it is the other traumatic event, it is hisologic Examinating the inclinity or other traumatic event. 1 Yes 2 No Hancock Bucksport Directo Maine 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 04416 USA 48 Lee Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 🛣 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bindery Worker US Government 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leo A. Ermer Addie Stogsdill ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Merry - Daughter 48 Lee Street, Bucksport, Maine 04416 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
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important: if ite
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once. 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Memorial Gdns 6-16-2006 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) M00053 21. Signa 22. Name and Address of Facility 3035 Old Washington Road POB 156, Waldorf, MD 20604 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires thet the death certificate be executed use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s certificete has 1 Yes 2 No Division of Vital ; After this certifical funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after death. To the Funerel Director; A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Func 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the e 29b. Signature and tile 29c. License number 29d. Date signed (Month, Day, Year) D0062223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Praveen Bolarum MILL STACET HAGERSTOWN MO - 21740. 340, MILL ST, 31. Date filed (Month, Day, Year) 32. Red State JUN 12 2006 Registrar

Shawn Alexander Allen

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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The form of the control of the contr			214-15-4290 1XM 2F		Months Days Hours	Min	Forei	gn N/D
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This is a consequence of the country of the count	hours 'natur			durin			16b Kind of Business/	Industry
This is a consequence of the country of the count	136 thin 72 ne than '	nple		+ or 5+)	Server		Restaur	cant.
This is a consequence of the country of the count	5-0(iled wi Hygier I other the M	ပ			18.Mother	s Name (First, Middle, I	Maiden Surname)	
This is a consequence of the country of the count	2121 Ild be f Mental marked event,			19h Ma				7.0
This is a consequence of the country of the count	MD 2 shouth and 37 is umatic	٦		9				e, Zip Code)
This is a consequence of the country of the count	re, les land stand of Healt littern in trans		20a Method of Disposition	20b. Place of Dis	position (Name of cemetery,		20c. Location - City or	Town, State
This is a consequence of the country of the count	Limo Page ment o tant: or oth		4 Donation 5 Other Specify.	Cremator	y of Delmarva	6/12/2006	Delmar, I	Œ
Pays Grant Pay	Balt permit Depart Impor injury		21. Signature of Funeral Service Licensee	2	2 Name and Address of Facility Lewis N. Watsor	n Funeral H	ome	
The months of Cause. (Pinned disease or condition resulting in death) Sequentially list conditions. Due to (or as a consequence of). D	Physician		23a. Part I. Enter the disease, or complications that cau	sed the death. Do not ent	1618 West Rd., er the mode of dying, such as ca	Salisbury, ardiac or respiratory arre	MD 21801 est, shock, or heart	
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Use to (or as a consequence of). Due to				onsequence of):				
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29b Signature and title of certifie 29c License number O.C.M.E. June 7, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 31. Date filed (Month, Pay, Year) 2 2006 32. Registrar's Signature	Sior Attend death ector: by the	catic	2 ✓ Accident Investigation Jun 6, 200	06 1848 hrs				
29b Signature and title of certifie 29c License number O.C.M.E. June 7, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 31. Date filed (Month, Pay, Year) 2 2006 32. Registrar's Signature	Divi	ertifi	- Suicide - Godid Hot be			or Town, St	ate)	
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O.C.M.E. June 7, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 31. Date filed (Month, Pay, Year) 2 2006 32. Registrar's Signature	To the within To the Comple	ledic	one) 2 Medical Examiner: On the basis of and manner state	examination and/or investi	gation, in my opinion, death occ	urred at the time, date a	and place, and due to the	e cause(s)
30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar 31. Date filed (Month, Pay Year) 2 2006 32. Registrar's Signature	12	2	29b. Signature and title of certifier		1			nth, Day, Year)
Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State Registrar Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature Registrar	120		30. Name and address of person who completed cause	of death (Item 23a)	J.C.IVI.L.		June 7, 2000	
regional factories (fr. Apriles)	V	t b	Carol Allan, MD Assistant Medical Ex	,	n Street, Baltimore, MD	21201		3
regional factories (fr. Apriles)	St	ate	31. Date filed (Month, Day, Year) 2 2006 32. Red	strar's Signature	A			
	rtegisi	1101		OPICIA	JAI		<u>.</u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 06 Richard Bryan Clarence /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1∭M 2□F Days 183-12-4170 83 Director Feb. 8, 1923 Penna Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location ortant: if tiem 27 is marked other then "natural; or tieme 23s or 28s-f show injury or other traumatic event, its Medical Examinar must be rediffed at 10d. Inside City Limits 1 Yes 2 No Be Completed by Funeral Director Greencastle Franklin Penna. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 17225 237 East Baltimore St. 12. Was Decedent Ever in U.S.
Anned Forces?
1 Des 2 Des 19 No
19 Yes, Give
Year or Dates: 19 3 - 19 16 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelih and Mental Hygiene. Important: if tiem 27 is marked other then "natural", or iten eny injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mack Truck Mfg. Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Effie V. Cramer Adam Walter Bryan P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 237 East Baltimore St. Greencastle, Pa. 17225 Brenda Bryan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 6/17/06 Greencastle, PA. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Lice and Marten 45 S. Carlisle St. Greencastle, Pa. 17225 23a. Part1. Enter the disease, or comshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Dale of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1. Impatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No Director: / investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide within 24 hours e 1 Certifying Physician: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as slated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number se of death (Item 23a) (Type, ne and address of person who complet 111110 111 Date filed (Month, Day, Year) 32. Pigistrar's Signature State **JUN 23** 2006 Registrar

Please Type or Print in Black Indelible Ink 06-04179 State of Maryland / Department of Health and Mental Hygiene Vicki Buesgens 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day June 16, 2006 1805 hrs **Medical Examiner** Victoria Lynn Buesgens c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore St. Agnes Hospital If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Days Months Country) New York Director 1 M 2X F Feb 26 1961 45 102-46-9169 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 1 Yes 2 X No s 23a or 28a-f shov notified at once. Goldsboro Maryland Caroline death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 14482 Poplar Street 21636 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status items ust be Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No Yes 9 1 Yes 2 X No specify: Specify: White Divorced If Yes, Give Year hours after Widowed ð 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exami Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 real estate industry 04 real estate agent 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nancy Butteon Czerkies Be John Czerkies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14482 Poplar Street Goldsboro, Maryland 21636 Peter Judd Buesgens/ husband 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition Baltimore, crematory or other place) Cn Burial 2 X Cremation 3 Removal from State 06/19/06 Chester, Maryland Chesapeake Cremation Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home 39 PA Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Cardiac Arrythmia Immediate Cause (Final disease 'xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Médical item#23a,27,perME,g857,7/24/06 TT X UNPENDED AMENDED attending physician Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy use as the 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I s been signed by to should be detached Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ⋧ Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No After this certificate page 26 Place of Death (Check only one) 25 Was case referred to medica Be Other₄ examiner? DOA Nursing Home 5 Residence 6 2 FR/Outpatient 3 Inpatient ۵ 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 2Bd. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural 1 Yes 2 No 5 Pending To the Funeral Director: Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

hours after death.

DHMH 17 Rev 1/2001 OCME 2006

Medical

State

Registrar

one)

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day, Year)

IIIN 23

Registrar's Signature

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 17, 2006

			1 - For State RegistrarAMEND #10open	State of Ma FH6/9/06,BM	•	-		nt of H <i>te of L</i>		and M	ental Hy	giene Reg. No	- 7 11 1	06	Electronic de la constante de	9919
			1. Decedent's Name (First, Middle, Last,		-						2. Date of D Month	eath Da	v Y	ear	3. Time	of Death
	Physici /Medic		Colleen Theres	e Boland							June	7,20	06		6:5	Opm M
	Examin		4a. Facility Name (If not institution, give					y, Town, or		of Death			. County of			
			11221 Stephalee La		- /l	last birthday)		ckvil.	Le If Under:	24 Hrs	8. Date of B		Montg			e or Foreign
	Funeral Director		10	х]м 23X]F	56 56	Yrs.	Month:		Hours	Min.	Month, D	av. Year		Count	land	_
			215-52-9164 Usual Residence of Decedent		- 50		l				nay 10	, 177		ital y	Tana	
	how .	. [10a. State 10b. County			y, Town or Lo		a						10		City Limits
	Ba-f.	cto	DC		Was	shingt										es 2 No
	를 or 2	Dire	10e. Street and Number				10f. Z	ip Code	_				tizen of Wh		•	
	s 23s	ia	5129 Watson St.,N		Towns in th	6 42	Man Dan	2001		-1-2/5	afr Van an N		ted S			
36	be filed within 72 hours after death with the Maryland hal hygiene. Id other then "natural, or liems 23a or 28a-f show other then "natural, or liems 23a or 28a-f show event, I'se Medical Examerer must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ♣ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2000 If Yes, Give Year or Dates:				edent of Hi ecify Cuba	Spanic Origin, Mexican Specify:	gin? (Spe n, Puerto i	crfy Yes or N Ricaл, etc.)	0-	Black,	White, e	etc.	•
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15	n n 7	pie	(Specify only highest grad	le completed) College (1-4or 5	(+)	(Give	kind of v DO NOT	vork done d use retired	<i>luring</i> mosi)	t of workii	ng					
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Baltimore, Maryland 21215-0036	Pages 1 and 2 should be filed within frinent of Health and Mental Hyglene-tant: If Item 27 ie marked other then "Hygges other traumatic event, I'm Market	1	19a. Informant's Name/Relationship (T) Michael Boland/B			4	-				Mac, MD	-		ate, Zip	Code)	
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ō	nt of it		1 Burial 2 □ Cremation 3 □ F		C	emetery, crei ate Of	natory of	other plac	· .	6-10	-06		ver S			
Ē	permit. Pages Department of Important: If any injuger any injuger		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		3						seph G					
Ba	permit. Departr Imports any ink		> Getelan B	Low 2							,N.W.					16
ſ	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each lin Breast a	Cano	cer,Me			g, such as	cardiac o	r respiratory	arrest,			Approxin Interval E Onset ar 3 ye	Between Id Death
8760,	The law requires that the death certificate be executed as the has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit of	dical Examiner	if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as												
P.O. Box 6	thet the death certific ed by the ettending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	death 3	⊒Ectopic ⊒ Other (pregnancy specify)					23d. Date of Month		ry Day	Year
	quires thet n signed b old be deta	Ď	Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the u	nderlying	cause give	en in Part I			tobacco Yes 2	use contribi			of death?
of Vital Records,		Completed							-		24a. Waa auto pen 1 □ Yes		dea	ore autop or to con ath? Yes		gs available if cause of
/ita	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?							of Death	(Check only	one)		M	u her	s Home
<u>></u>	hyen this c	ဥ	f Yes 2 No	Hospital: 1 Inpatie		ER/Outpatier			+ - 110		ne 5 Res			(Specify		D Troine
Division (To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification;	27. Manner of Death Sample Natural Sample Pending 2 Accident Investigation 3 Suicide Sample Could not be	28a. Date of Inju (Month, Da		28b. Time o Injury	М		/ at <br Yes 2 □	No	28d. Describe					
Divi	ital or Att	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho	ome, farm, str	reet, fact	ory, office			28f. Location City or To	(Street al own, Stat	nd Number e)	o <i>r Rur</i> ai	Route N	umber,
	To the Hospital of within 24 hours af To the Funerel D completely filled in	edicai		iner: On the basis of and manner st	fexamina											e(s)
	within To th compl	Me	29b. Signature and title of certifier				2	9c. License	number			29d. Da	ite signed (i	Month, L	Day, Year)
	G) Ourse	elle	G			MD 4	0216			Ju	ne 8,	2006	Ò	
	U		30. Name and address of person who o													
			Dennis Cullen, M.D.				e,Be	thesd	a,MD							
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	ature de	de									

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BLAKE Month **Physician** Year DAVID ANDREW 1:40 AM June 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CITIZENS CARE + REHAB. CENTER FLEDERICR FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ØM 2□F JAMAICA Director 089-48-4665 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at Md. FREDERICK FREDERICR 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Cheltenham 21702 2184 V. S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: BLACK 3 ☐ Widowed 4 Ø Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working d 2 should be filed within 7: ih and Mental Hygiene. 7 Is markad other than "n. Elementary/Secondary (0-12) Post College (1-4or 5+) Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BIAKE Kudolph largaret Ebanks 19a. Informant's Nam Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is in any injury or other treum 900.9. New York 10023 Dakota Blake daughter 73rd St. New Jork 256 W. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State June 13, 2006 FREDERICK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FONORAL 21. Signature of Funeral Service Licensee Day X. FROBERICA 21701 SOVIH ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician KENAL disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit the attending physician Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 No 25. Was case referred to medi 1 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 😭 No 1 Inpatient 2 ER/Outpatient this 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Hospital or Attending P. 24 hours after death.
 Funeral Director: After to Certification: 28d. Describe how injury occurred After 1 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifie Date signed (Month, Day, Year) 30. Name and address of eath (Item 23a) (Type, Print buse Ave U-1 State **JUN 12** Registrar

		•	For State Registrar	State of Maryland / Dep Ce	ertificate of Death		ene∠UUb g.No.	1992
	Physici		Decedent's Name (First, Middle, Las	•		2. Date of Death Month	Day Yeer	3. Time of Death 9:50
	/Medic			Lantes		June	8 2006	a '''
	Examin	er	4a. Facility Name (If not institution, give 8700 Ridge Rd		4b. City, Town, or Location of Deat Ellicott Cit		4c. County of Death	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs	-		place (State or Foreign ntry)
6.	Director		088 48 7360	□ M 2 1 90 Yrs.	Months Days Hours Min.	June 29	1915 Phi	lippines
	pur *		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	Location			10d. Inside City Limits
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	28a-	Director	10e. Street and Number	A DITEO	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	h with	a D	8700 Ridge	Rd. Apt 411	21043		USA	
	ema series	Funeral	11. Marital Status		. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	1 ☐ Yes 2727 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐No Specify:		Specify:	
21215-0036	72 hours after death with the Maryland natural; or terma 23a or 28a-f ehow incal Exandrec must be notified at		15. Decedent's Ed	ucation 16a. Dec	edent's Usual Occupation	10	6b. Kind of Business/Ir	nite ndustry
215	within 72 ene. than "ne he Medil	Completed	(Specify only highest gra-	de completed) (Giv	re kind of work done during most of wor DO NOT use retired)	rking		·
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Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event.	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma	aiden Sumame)	
Z S	d Mental narked o	ဥ	Calixto Martinez 19a. Informant's Name/Relationship (7)	ime Print) 19h Ma	Ing Address (Street and Number or Ru	a Leones	City or Town State Zi	n Codel
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health at I armarked other than "natural", or thema 23a or 28a-f show item 27 is marked other than "natural", or the modified at other traumatic event. The Medical Experience must be notified at		Edita Nadel/Daught		elladonna Court Ow			
6	of Health of Health litem 27 I		20a. Method of Disposition	20b. Place of Disposer			0c. Location - City or T	
Ë	Pages nent of int: If if		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	epherd Cemetery 6-	-15 – 2006 E	llicott Ci	ty, MD
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service bicer	500	22. Name and Address of FacilityHar	ry H.Witz	ke's Famil	y F.H.Inc.
Ш	20 E E G		mare FC	/// MOO845	4112 Old Columbia	<u>Pike Elli</u>	cott City.	Md. 21043 Approximate
			shock, or heart failure. List only a	olications that caused the death. Do not e		or respiratory arres	51,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Alzheimer's Due to (or as a consequence of):	Disease			8 years
45	Examiner			. Due to (or as a consequence or).				,
W.	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	acuted and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
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68760,	phys s the	edical		d				
Вох (leath certifi attending I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	ery
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P.0	ac of	Phys	9 Unknown			an- Didanh		
	es ign be	by		intributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	
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Rec	e lav has je 2	Completed	Atrial fib	rillation		24a. Was an autopsy performe	ed2/ prior to co	opsy findings available ompletion of cause of
tal	ician: Th certificate rector, pag	e e	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 ☐ ath (Check only one)	ZNo 1 ☐ Yes	2 № No
f∨i	Physicia this cert al direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Othor		ce 6 ⊡Other (Speci	fy)
0 4	Attending Physician: It death. ector: After this certific by the funeral director,		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how	injury occurred	
sio	ttendi death. ctor: A / the fu	catl	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	20t Landing (Cha		10
Division of Vital Records,	or At after o Direction by	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	City or Town,	eet and Number or Rur State)	ai Houte Number,
	Hospital 4 hours a Funeral I	al C	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, de	ath occurred at the time, date and place	, and due to the cau	use(s) and manner as s	stated.
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examone)	iner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	irred at the time, dat	e and place, and due t	o the cause(s)
	To the within 2 To the compler	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Month,	Day, Year)
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5)00	-		1 1 1	completed-cause of death (Item 23a) (Type	- 11 .0 1 1	thousil	L MD	21093
W.	Sta	te	31. Date filed (Month, Day, Year)	mf ord 10755 32. Resistrar's Signature	rall > Ral, Lu	I VIEVVIII	0, 11-	-10/0
1	Regist		JUN 1 2	2006 32. Redistrar's Signature	boule			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 3:06 A Norene Jean Baker June 6, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | 5-30-1932 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 X F 579-40-2372 Washington, DC Director 74 Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland estiment of Health and Mental Hygiene.

ortant: If Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow Injury or other traumatic event, the Medical Examinations to be maillied at 10c. City, Town or Location 10d Inside City Limits 10a, State 10b. County 1 XYes 2 ☐ No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20781 USA 4221 Oglethorpe St. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No White If Yes, Give Year or Dates: Specify: δ 3℃Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Ritnour Helen Ryan ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Colony Crossing, Edgewater, MD 21037 Dana A. Thrift/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny Injury or 4 □ Donation 5 □ Other (Specify) Lakemont Cemetery 6-10-06 Davidsonville, MD 21. Signature of Funeral Service Lizensee 22. Name and Address of Facility George P. Kalas Funeral Home WIO Male 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consec Examiner ed by the attending physicien end detached for use as the burial-transit resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has pege 2 autopsy performed After this certificate 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: ners! Director: After this certific filled in by the funeral director, within 24 hours e To the Funeral C

Baltimore, Maryland 21215-0036

29c. License number

29d. Date signed (Month, Dev. Year) JUNE 6, 2006

ed cause of death (Item 23a) (Type, Print)

and manner stated

M. D. 7610 CARROLLAVE. SUME 410. TAKOMA PARK 20912

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

		*	For State Registrar		State of M	larylan		artmen rtificat			d Men		iene •g. No.	200)6	1992
	Division		1. Decedent's Name (First,	Middle, La	st)			*				Date of Deal				3. Time of Death
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	Examir		4a. Facility Name (If not inst	titution, giv	e street and number	")		4b. City,	Town, or	Location of D	eath		4c.	County of	Death	
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	Funeral		5. Social Security Number	6. S	ex 7. A Mg M 2 □ F	ge (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 24 I Hours N		Date of Birth Month, Day,	Year)	9	. Birthpla	ace (State or Foreign
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	72 hours after death with the Maryland naturel', or items 23a or 28a-f show dical Examinar must be notified at	Funeral	11. Marital Status	IIIOI	12. Was Deceden			Vas Deced	ent of His	spanic Origin?	? (Specify	Yes or No-		4. Race -		
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<u></u>	Pages nent of I int: If it		1 ☐ Burial 2 X Crema 4 ☐ Donation 5 ☐ Oth			•	emetery, crer			1						
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	Physician		Immediate Cause (Final disease or condition	Listony	No	$h \leq a$	nall 1	011	1	00						Interval Between Onset and Death
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Вох	leath certific ettending p	lan	23b. Was decedent pregnar in the past 12 months?		23c. If yes, outcome	2 Fetel	death 3	Ectopic pre					2	3d. Date o Month		/ Day Year
	the the	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant a 9□Unknown	it time of de	eath 5∟	Other (spe	ecify)					141017017		, our
P.0	thet the		Part II. Other significant co	nditions c	ontributing to death	but not resu	ulting in the u	derlying ca	aven asu	n in Part I		23e Did tob	2000 118	e contribu	to to the	cause of death?
Records,	uires the signed Id be de	d by	•		-			.conyang co	-000 givoi	, m. r. ca.v. r.		1/	s 2			oly 4 Dunknown
Ö	w requ	Completed									-		Y			
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Division	Attending ir death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ C	ould not be		jury - At ho	me, farm, stre				28f. L	ocation (Str	eet and	Number o	r Rural I	Route Number,
Ö	after Dire	Certification:	4 Homicide	9(9))))))	building, e	tc. (Specify)	, , , , , , , , , , , , , , , , , , , ,				City or Town	State)			TODIO TOTALONI
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier Certifier (Check only one)	tifying Ph dical Exam	ysician: To the best niner: On the basis of and manner s	of examinat	wledge, death ion and/or inv	occurred a	at the time in my opi	, date and pla nion, death o	ace, and d	ue to the ca the time, da	use(s) a te and p	and manne place, and	r as stat due to ti	red. he cause(s)
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			1 - For State Registrar		Marylan		artment o				g. No. LU	06	19924
1	Physici	an	1. Decedent's Name (First, Middle Shellie	Clawson						2. Date of Death Month	Day 2006	Year	3. Time of Death 2:15 P M
A	/Medic Examin		4a. Facility Name (If not institution Prince George's	, give street and numb		tal		n, or Location	of Death	May 21	4c. County	of Death	2:15 8 ***
(9).	Funeral Director	y.	5. Social Security Number 250–12–9130			last birthday) Yrs.	If Under 1 Yo Months Da	ear If Unde	Min.	8. Date of Birth Month, Day 04/23/1919	Year)	Cour	place (State or Foreign
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	reation					- 1	0d. Inside City Limits
	Maryla febo	or	MD P	G		Mitchell							1 StYes 2 □ No
	1 the 1	Director	10e. Street and Number				10f. Zip Cod	de		10	g. Citizen of V	Vhat Cour	ntry?
	th with	ai D	933 West Lake Dri	ve			20	0721			USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28e-f ehow any Injury or other treumatic event, I're Medical Exertifical must be notified at DDGe.	by Funerai	11. Marital Status 1 Never Married 2 Marr 3X Widowed 4 Divorced	12. Was Deced Armed Forc ied 1 X Yes 2 If Yes, Give Year or Date	es? □No		Was Decedent If Yes, specify (1 ☐ Yes 2 🕱			cify Yes or No- Rican, etc.)	Blac	e - Americ k, White,	_
2-0	72 ho	Completed	15. Deceden (Specify only highes				dent's Usual Ockind of work do		est of working	10	6b. Kind of Bu	siness/In	dustry
121	ne. hen "	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use re	tired)		9	77-3	1 0	
Q 0	Hygie Hygie other t		6th 17. Father's Name (First, Middle,	Last)		ПС	nerator	Operato		(First, Middle, M			emment
Maryland 21215-0036	hould be d Mental marked c	To Be	John Clawson , S			10h Mailir	an Address /St			Unknown I Route Number,	City of Town	Ctata Ti-	Code
Z	ith an Ith an 27 is r		Jeannette Clawson				_			llville, M		зіаів, гір	(Code)
Baltimore,	Pages 1 arent of Heam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from St	ate C	Place of Dispo cemetery, crer	sition (Name of matory or other lat 1 Ceme	f place)		ate 2	oc. Location -		
Baltir	permit. F Departmi Importar any Injur		21. Signature of Funeral Service		nai	22	. Name and Ad	dress of Faci	lity				VD 20737 Riverdale,
	Physician		23a. Part1. Ententhe disease, or shock, or heart failure. List Immediate Cause (Final disease or condition			h. Do not ent		dying, such a	s cardiac or	r respiratory arres	it,		Approximate Interval Between Onset and Death
8760,	Medical Examiner ohysicien and the burial-transit	ai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CONGE Due to (or PULM Due to (or	as a conseq ESTIVE as a conseq ONAR as a conseq ATEN	uence of): HE uence ol): HH uence ol):	ART IPERTE	FAILU ENSID	RE				
Box 687	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		incy	Ectopic pregna	ancv				o ol delive	
P.O. E	that the death certific ed by the attending p detached for use as	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		it at time of d		Other (specify				Mor	ith	Day Year
	w requires that been signed should be de	ρ	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the u	nderlying cause	given in Part	l.		_	ibute to th 3 🗌 Prob	ne cause of death? ably 4 Munknown
l Reco	The ate h page	Completed								24a. Was an autopsy performe	g? p	rior to cor eath?	psy lindings available npletion of cause of
/ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			17.12				Check only one			
Division of Vital Records,	Phys this aldi	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig	9		ER/Outpatien 28b. Time of Injury	28c. I	Other: 4 N njury at Work? 1 Yes 2	2	ne 5 Residen 8d. Describe how			()
Divisi	in the se	Certification:	3 Suicide 6 Could in determine	not be 28e. Place of	Injury - At ho , etc. (Specif		eet, factory, off			81. Location (Stre City or Town,		or or Rura	l Route Number,
	To the Hospital or Attending i within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	edicai C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the be Examiner: On the bas and manne	is of examina	wledge, death	n occurred at the vestigation, in n	e time, date a ny opinion, de	nd place, a ath occurre	nd due to the cau d at the time, dat	se(s) and mar e and place, a	nner as st nd due to	ated. the cause(s)
	To th To th	Me	29b. Signature and title of certifie		/		29c. Lic	ense number	// 5	1	J. Date signed		
2	(10)		30. Name and address of person	GEORGE	31	001 H	Print) OSPITA	- DR	, ,	CHEVER.	LY. M	700	20185
*	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 2 20	32. Reg	istrar's Sirma	ature	No.			<u> </u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Veer 4:16 1ARie SITTA! COLEMAIN 2006 4a. Facility Name (If not institution, give street and number) 4b, City, Town or Location of Death 4c. County of Death 10005 bun WOSHINSTON WOSHINGTON CUNIC If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Davs Hours 1 ☐ M 2 💢 F 233-34-3357 14, 1927 West . Vi<u>rginia</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Knoxville Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1111 Hoffmaster Road 21758 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 ▼No
If Yes, Give 7
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specity: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mollie Zetta Nichols John Robert Dodson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Kuhn - Daughter 1129 Hoffmaster Road - Knoxville, MD 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 □ Other (Specify) Samples Manor Cem. 6/13/06 Sharpsbur, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eackles-Spencer Funeral Home M970 Harpers Ferry, WV 25425 01 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alca(V)Sis Due to (or as a consequence of): Due (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Dav 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cite 26. Place of Death | Check only one;

Physician /Medical Examiner Examiner

burial-transit

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page 2 s

certificate After this certifical funeral director, r

or Attending Physician:

death. filled in by the within 24 hours after deat To the Funeral Director:

Physician/Medical

Be Completed by

Certification: To

Medical

physicien

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

in than "natural", or Items 23a or 28a-f show The Medical Examinat must be nutified at

Hygiene.

and Mental h

permit. Pages i Department of h Important: If ite ony injury or ot once.

Pages 1 and 2 should be

other treumatic event,

Completed by Funeral Director

Be

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MD

filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? Hospital: Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA

27. Manner of Death 5 Pending investigation Natural 2 Accident 6 ☐ Could not be 3 Suicide

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

4 Homicide

31. Date filed (Month, Day

29a. Certifier

32. Reg

29c. License numbe

29d. Date signed (Month, Dey, Year)

use of death (Item 23a) (Type, Print)

State Registrar

completely

			For State Registrar	State of Ma	aryland /		irtment of H		nd Me		ene 2 (06	19926
			Decedent's Name (First, Midd	le, Last)					2	. Date of Death)		3. Time of Death
П	Physicia		Gladys	Lucy Ca	ardare	elli				June 6,	2006	Year	2:37 p M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)			4b. City, Town, or	Location of			4c. County	of Death	
			Calvert Memori	al Hospital			Prince	e Frede	eric	ζ	Ca	lvert	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last		If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. g Min.	Date of Birth (Month, Day, 15)	Year)	Coui	
	Director		070-07-9619 Usual Residence of Decedent	1	94	Yrs.			N	Mar. 15	,1912	New	York
	land Sw		10a. State 10b. County	,	10c. City, To	own or Lo	cation					1	10d. Inside City Limits
	Many - sh	to	MD Cal	vert	Н	[unti	ngtown						1 ☐ Yes 2 X No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	th with		4605 Greenric	lge Court			206	539			U.S	.A.	
	within 72 hours after death with the Maryland ene. Than "naturel", or items 23a or 28a-f show the Modical Examinat must be mullised at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origi n, Mexican,	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		ce - Americ ck, White,	can Indian, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorces	If Yes Give**	No		☐ Yes 2X No	Specify:			Specif	y: v	white
21215-0036	2 hou		15. Deceder	nt's Education	16		lent's Usual Occupa			1	6b. Kind of B	usiness/In	dustry
215	thin 7 9.	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5	5+)	life. L	kind of work done o OO NOT use retired	iuring most o	ot working				
7	ad wit	Con	5			h	omemaker					home	>
nd	be file	Be	17. Father's Name (First, Middle,							First, Middle, M	aiden Suman Palumb		
ryla	d Mer marke	은	Peter 19a. Informant's Name/Relation:	Fasolino	1	9h Mailin	g Address (Street a	Anna					2 Code)
Maryland	Ith an 27 is it reui		Joseph P. Carda				Greenrid					206	′
re,	s 1 ar f Hea ltem other		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of	a)	Dat	е 2	Oc. Location	-	
<u>m</u>	Page nent o ant: If ury or		1 🎇 Burial 2 □ Cremation 4 □ Donation 5 □ Other (\$		Holy	Sepi	ilćhre Ce	metery	y 06–	·10–06 C	heekto	waga	, NY
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene is Teparated to the Table of the Tab		21. Signature of Funeral Service	Ligentee / Leeba	ch		. Name and Addres ausch Fur		Home,	, P.A.,	Owing	s, MI	20736
			23a. Part1. Enter the disease, of shock, or healt failure. Lis	r complications that caused t only one cause on each lin	the death. D	o not enti	er the mode of dying	g, such as ca	ardiac or r	espiratory arre	st,		Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	Polenon		Enl	merla						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):							
		7	Sequentially list conditions,	b. Due to for as	a cisonia iuliano	se offi						-	
	nsit	mine	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<									
Ć,	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequenc	ce of):							
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai		d									
9	artifica ing pt e as t	Med	IF FEMALE:										
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)					te of delive onth	ery Day Year
P.0.	that the de ad by the a detached	ysic	1 □ Yes	9□ Unknown	time of death	3	Other (specify)						
		by Ph	Part II. Other significant conditi	ons contributing to death b	ut not resulting	g in the ur	nderlying cause give	en in Part I.		23e. Did toba	acco use cont	ribute to th	ne cause of death?
rds	requires seen sign hould be	q pa	Type 2 Die	Lotu Mellit	A7,					1 ☐ Yes	2 □ No	3 🗆 Prob	pably 4 Unknown
Records,	> 1 S	Completed	Coverous Ar	tom Dissail						24a. Was an autopsy	24b.	Were auto	psy findings available impletion of cause of
Ä	0 5 0	mo.	/	,		-	-			perform	arl?	death?	
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to medica examiner?					26. Place o	of Death (Check only one			
of <	Physician: this certific ral director,	ို	1 ☐ Yes 2€No	Hospital:			DOA Othe	4 14015		5 Residen			y)
n c	ing P	inol inol	27. Manner of Death 1 ⊠Natural 5 □ Pendi		ry 28t y Year)	D. Time of Injury	28c. Injury Work	(?		d. Describe hov	v injury occur	red	
isic	Attending r death. sctor: After by the fune	icat	3 Suicide 6 □ Could		uny - At home	form str	M 1 1	Yes 2 □ No		Location /Stre	et and Numb	er or Rum	I Route Number,
Division	after death after death Director: /	Certification;	4 ☐ Homicide determ	building, et	c. (Specify)	, 141111, 3116	set, factory, office		2.01	City or Town,		0, 0, 11212	ar route rumber,
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C		ng Physician: To the best Examiner: On the basis of and manner sta	examination								
	Fo the	Me	29b. Signature and title of certific				29c. License	number		29	d. Date signe		,
)	0		1 Dans	lordy MD			047	610			June -	7, 2	006
	1		30. Name and addressor person	who completed cause of d	eath (Item 23a	a) (Type,	Print)						
	6		David J. Tardio					Prince	e Fre	ederick	MD :	20678	
	Sta Registr		31. Date filed (Month, Day, Year JU)	32. Registra	Signature	H.	Sparte						

State of Maryland / Department of Health and Mental Hygiene 2 0 6 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Elizabeth Dumire Connor 0813 June 10 2006 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional alisbure Penysula 11 Comics Social Security Number Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8/10/1926 Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🛣 F Hours 235-36-6874 79 Director West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location *oue 10d. Inside City Limits ir then "natural", or items 23a or 28a-f eho The Medical Examiner must be notified at Director 1 TYPes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 600 Edgewater Drive 21801 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Wicomico County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be .
Department of Heelth and Mental H important: if item 27 is med.
eny injury or other. Peter Ghost Beatrice Stump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla E. Brooks/daughter 500 Harbor View Dr., Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Salisbury Crematory 6/12/06 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ cate has been sig page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? congestive 1 ☐ Yes 1 Yes 2 No 2 -NO 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 100 1 ☐ Impatient 2 ☐ ER/Outpatient this 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural To the hosping after death, within 24 hours after death.

To the Funeral Director: Aft 5 Pending 1 ∏Yes 2 ∏No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Janea D15384 JUNE 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODNEY A. INENRICH 1346 S. DIVISION ST. MD SALISBURY 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar JUN 12 2006

ORIGINAL

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of Vital

Division

Elizabeth Comor

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I rtificate of	Health and I <i>Death</i>	Mental Hygie		5 1992
	Dhamia		1. Decedent's Name (First, Middle, La	•				2. Date of Death		3. Time of Death
	Physic /Medi		Julice I)avis				June	3, 2006	6:30P M
	Examir		4a. Fecility Name (If not institution, given	re street and number)		4b. City, Town,	or Location of Death	1	4c. County of Dea	
			308 Possum Court			Capito	1 Heights	3	Prince (George
	Funeral			Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yo	9. Bi	thplace (State or Foreign ountry)
	Director		230-42-5348	TESIM ZUP	80 Yrs.		1,155,15	March 31	1926 Sou	th Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f ehc	ŏ	Maryland Prince	George		Heights				10d. Hiside City Emilis
	the 28a	Director	10e. Street and Number	000160	Capitor	10f. Zip Code		100	Citizen of What C	
	3a or		308 Possum Cour	t		207	43	109.	United S	•
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or iteme 23a or 28e-f show matic event, the Medical Exeminar matic he incitified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of I	Hispanic Origin? (Si	pecify Yes or No-	14. Race - Ame	
٩	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣	No		Hispanic Origin? (S an, Mexican, Puert	Rican, etc.)	Black, Whi	te, etc.
3	ral', o	l by	3. Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: 1	Black
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yland	8 4 2 8	Be	17. Father's Name (First, Middle, Last Charlie Davis)				ne (First, Middle, Mai Streater	den Sumame)	
Ž	should nd Men marke imatic	2								
Nar	2 6 5 7		19a. Informant's Name/Relationship (ral Route Number, Ci		Zip Code)
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وَ	00		1 ☑ Burial 2 ☐ Cremation 3 ☐		Church in	natory or other pla	d l	Date 200	. Location - City or	Town, State
saltimore,	permit. Page Department Important: If any injury o		4 Donation 5 Other (Specif		Christ Ce	metery	June	10,2006Ch	esterfiel	d, SC.
g	Depa mpo my i		21. Signature of Funeral Service Licer		22	. Name and Addre	ss of Facility P	ope Funera 538 Marlbo	1 Homes	
			230 Port 1 Entry the display or one	yeary			F	orestville	MD. 2	0747
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each li	ine death. Do not ent	er the mode of dylr	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Dew	rentia	·				Onset and Death
	Examiner			Due to (or as	a consequence of):	1	N	111		
		ă	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	ecur	itus	Ulcer		
	uted I Insit	를	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	220 10 (01 20	2 22.100420.100 017.					
ń	be executed icien and burial-transit	Examin	resulting in death) Last	Due to (or as	a consequence of):					
0/0C,	icate be executed physicien and s the burial-transit	dical	(d						
	tificate g physi as the l	0		-						
200	w requires thet the death certific been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deli	iverv
0	deat de attr	icia	in the past 12 months?	4☐Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
5	t the by th tache	hys	9 🗆 Unknown	9□ Unknown						
, C	an the	by P	Part II. Dther significant conditions of	ontributing to death bu	it not resulting in the ur	derlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
2	an sig							1 ☐ Yes	2 No 3 ₽r	obably 4 Dunknown
5	awre is be	Completed						24a. Was an	24b. Were au	topsy findings available
č	The I	E						autopsy performed	prior to death?	completion of cause of
<u> </u>	an: rtifica tor, p	Bec	25. Was case referred to medical				26 Place of Deat	1 Yes 2X	No 1 ☐ Yes	2□ No
>	ysic:	20	examiner? 1 ☐ Yes 2∑ No	Hospital: 1 Inpatie	nt 2 ER/Outpatien	3□ DOA Oth		me 518 Residence	6 FlOther (Coor	2.6.1
2	ig Ph ter th veral		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injun Work		28d. Describe how in		лу)
5	tending Physician: The lavisath. feath. tor: After this certificate has the funeral director, page 2	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury		Yes 2 □ No			
2	er de recto by th	울	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, stre	et, factory, office		28f. Location (Street	and Number or Ru	ral Route Number,
2	ital o	Certification:		Dundary, etc	- (Opecity)			City or Town, Sta	118/	
	To the Hospital or Attending Physician: The law requires thet the death certif within 24 hours after death certif within 24 hours after decrease a completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☒ Medical Exam	ysician: To the best of	f my knowledge, death	occurred at the time	ne, date and place,	and due to the cause	(s) and manner as	stated.
	the hain 24 the F	Medicai		and manner sta	examination and/or invited.	esugation, in my of	uriion, death occurr	ed at the time, date a	ind place, and due	to the cause(s)
	Twit Son Twit	2	29b. Signature and title of certifier	//	,	29c. License			ate signed (Month	
^			1/angl	yecc		009	5323	5 6	18/06	
	_(3)		30. Name and address of person who o			Print)				
1			Darryl Hill, M.D		altimore A	ve., Laur	el, MD.	20707		
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature					

			1 - For State Registrar	i icase i	State of I		•	artmen	t of H		and Me	ental Hy	giene Reg. No	201	16	199	929
	Obvoje	215	1. Decedent's Name (i	2. Date of De Month	aath 7 ^{Day}	, cooYe		Time of D	
	Physici /Medio		Charles A	. Dunnel	1, Jr.			,			J	lune				50P	М
	Examir		4a. Facility Name (If no	ot institution, give s	treet and number	er)		4b. City,	Town, or	Location o	of Death		4c.	County of I			
			Kline Hos						. Aiı		Od Ura				erick		
	Funeral		5. Social Security Num	1.	7. M 2□F	Age (In yrs. 85	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min. To	8. Date of Bi (Month, D	rth ay, Year)	9. 21 M	Birthplace (State or	Foreign
	Director	4	471-12-7894 Usual Residence of De			0.5	113.	L			JE	11. 10	172	111	innés	OLa_	
	land bw	-		Ob. County		10c. Cit	ty, Town or Lo	cation							10d. In	side City	Limits
	Mary f she	ō	Maryland	Frederic	k	Fr	rederio	·k							1	☐Yes 2	2 No
	28a	ec	10e. Street and Number		IC .		Cuciac	10f. Zip	Code				10g. Cit	izen of Wha	t Country?		
	3a or	0	500 J. Leah	v Court					2170)3			Unit	ed St	ates		
	death ms 2	Funeral Director	11. Marital Status		12. Was Decede	nt Ever in U	l.S. 13.	Was Dece			gin? (Spec	cify Yes or Na Rican, etc.)		14. Race - /	American Inc	dian,	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic svent, it a Mydical Examination institled at once.	T.	1 🗌 Never Married	2X Married	Armed Force 1 X Yes 2 If Yes, Give	ื้ท ₀1 94′	I — I			n, Mexican Specify:	i, Puerto P	tican, etc.)			White, etc.	_	
21215-0036	ral',	1 by	3 Widowed 4	Divorced	Year or Date	s: 1961	1	1 🗌 Yes	2 % NO	эрвспу.				Specify:	White	е	
5-0	72 h	Completed		. Decedent's Edu			16a. Dece	kind of wo	rk done o	luring most	t of workin	g	16b. Ki	ind of Busin	ess/Industry	,	
21	ithin Jan	dr.	Elementary/Second	ary (0-12)	Coilege (1-4	or 5+)		DO NOT ii)			DI		T _L		
2	lygie her t nt, IL		47 Fatharia Nama (Fi	unt Adiadalo (a ad)	+4		EHS	ginee	r	10 Matha	rio Namo	(First, Middle	-	ysics	Lao.		
ano	be fi	Be	17. Father's Name (Fit		1 0						ie Hi		r, Maideri	Surname)			
3	a Mer	2	Charles A				40h M-10		(0)				0:5	T 04-	4- 7:- 0-4-	1	
Maryland	12 sh n and r is n		19a. Informant's Name		-		100					Route Numb				9)	
	1 and lealth sm 27		Eileen Dur 20a. Method of Dispos		ite	20h F	_DUU J.			ourt,		lerick		cation - City		State	
Baltimore,	Pages nent of H ant: If ite		1 □ Burial 2 💢 🤆	Cremation 3 □R	emoval from Sta	ate C	cemetery, crei	natory or o	other place	.							
ŧΪ	t. Partmer		`4 □Donation 5			Fred	derick			y ()		/2006 1					
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н			23a Fart1. Enter the		ne cause on each	h life.	in. Do not en	er the mod	se or ayını	g, such as	cardiac or	respiratory a	irrest.		Inter	val Betwe et and De	eath
	Physician		Immediate Cause (Fir disease or condition resulting in death)	nai	End St	age Wr	ng Cano	er							1 1/	2 yr	•
	/Medical Examiner		, vocaning in county		Due to (or	as a conseq	quence of):										
		<u>_</u>	Sequentially list condi	tions,	Due to (or	as a conseq	mence of):										
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•	ate be executed hysician and he burial-transit	xar	that initiated events resulting in death) Las	t		as a conseq	uence of):										
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687	phys phys s the																
×	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pr	rognost 2	3c. If yes, outcor	me of pregna								23d. Date of	delivery		
Вох	atter for u	clar	in the past 12 mg	onths?	1□Live birth 4□Pregnan			Ectopic p					1	Month	Day	Ye	ear
o.	the d y the ched	ysl	1 □ Yes 2 □ N 9 □ Unknown	10	9□ Unknow			(-,	- ,,								
<u>α</u>	that led b	P	Part II. Other significa	int conditions cor	tributing to deat	h but not res	sulting in the u	nderlying o	ause give	en in Part I.		23e. Did	tobacco u	ise contribut	le to the cau	se of dea	ath?
Records,	urres signi	d b	Mit	ild Demer	ntia							10	Yes 2	∑No 3[Probably	4 □Un	iknown
00	w requir been si should	Completed										24a. Was	an	24b. Were	e autopsy fir	ndings av	vailable
Re	has ge 2	E D										auto		prior	to complete h?	on of cau	use of
a	n: Ti ficate or, pa		25 Was seen referror	I to modical						00 Place	-4 D4h	1 Yes		1 🗆	Yes 2LX1	Vo	
Vital	ding Physician: The lav h. Atter this certificate has funeral director, page 2	Be C	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No		lospital:		ER/Outpatier		Cthe			(Check only le 5 ☐ Res		V 10	. Но	spic	6
of	Physral distribution	To To	27. Manner of Death		28a. Date of I (Month,		28b. Time o		28c. Injury Work			8d. Describe				use	
on	ding Ih. Afte fune	‡ or	1 X Naturał 2 ☐ Accident	5 Pending investigation	(Month,	Day Year)	Injury	М		<br Yes 2∐1	No						
Division	Attandi death. ctor: A y the fu	fica	3 🗀 Suicide	6 Could not be determined	28e. Place of	Injury - At h	ome, farm, sti	eet, factor	y, office		2			d Number o	r Rural Rou	te Numbe	e <i>r</i> .
Div	after Dire	erti	4 Homicide	dotommod	building	, etc. (Specil	(y)					City or To	wn, State)			
	spita lours neral	Medical Certification;	29a. Certifier 1	Certifying Phys	sician: To the be	est of my kno	owledge, deat	h occurred	at the tim	ne, date and	d place, ar	nd due to the	cause(s)	and manne	r as stated.		
	s Ho 24 h e Fui	g	(Check only 2 one)	Medical Examin	ner: On the basi and manner		ation and/or in	vestigation	i, in my op	oinion, deat	th occurre	d at the time,	date and	place, and	due to the c	ause(s)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Me	29b. Signature and titl	e of certifier	1.1	1	.4	29	c. License	number			29d. Dat	e signed (M	lonth, Day,	Year)	
	C > F 0		> (0)	on K	Tell	4.	My)	D	5474	49			Jι	ine 8,	2005		
	9		30. Name and address	s of person who co	mpleted cause	of death (Iter	n 23a) (Type	Print)						,			
	J		Allen Rei		(. Fra	ederi	ck. M	id. 21	701				
	Sta	ate	31. Date filed (Month.				ature				, 1						
**	Regist		J	UN 128	UUb 📈	due	A A	MALL									

				partment of Health and Menta ertificate of Death	Hygiene Reg. No.2006 9930
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) Maria Jane Digges 4a. Facility Name (If not institution, give street and number) William Hill Manor	4b. City, Town, or Location of Death Easton	e of Death th 10,2006 11:10A 4c. County of Death Talbot
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	y) If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. Mor	o of Birth Park, 1922 9. Birthplace (State or Foreign Country) PA
	the Marylan 28e-f show cotified at	rector	10a. State 10b. County 10c. City, Town or MD Charles La P		10d. Inside City Limits 1 ☑ Yes 2 ☐ No 10g. Citizen of What Country?
	23e or	rai Di	603 Washington Ave.	20646	USA
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel', or Items 23e or 28e-f show appringing or other traumatic evant, I're Medical Examinational be notified at ance.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 Yes No Specify:	s or No- tc.) 14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	I within 72 ho iene. r than "netur Ine Modical	ompleted	(Specify only highest grade completed) (Gh Elementary/Secondary (0-12) College (1-4or 5+)	pedent's Usual Occupation we kind of work done during most of working DO NOT use retired) Omemaker	16b. Kind of Business/Industry Home
yland	could be filed I Mental Hyg varked othar	To Be C	17. Father's Name (First, Middle, Last) Dr.William A. McHugh	18. Mother's Name (First, M Gwendolyn	Middle, Maiden Sumame) Barnes
Mar	ind 2 sh alth and 27 is rr er traurr		71 171 - 1-	iling Address (Street and Number or Aural Aoute) andy Acres, Cambridg	
imore,	Pages 1 ament of He ent: If itam		20a. Method of Disposition * Burial 2 Cremation 3 Removal from State * Donation 5 Other (Specify) 20b. Place of Discemetery, or St. Ig1	position (Name of ematory or other place) natius Cem. 6/13/06	20c. Location - City or Town, State
Balt	permit. Departi Import any inj		Jane Capale	AREHART ECHULS FUNE 211 St. Mary's Ave.	La Plata,MD 20646
8760,	certificate be executed xx and ding physician and see as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death 2 day \$
O. Box 6	death e atter id for u	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ecords, P.	The law requires that the te has been signed by th age 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the Chronic obstructive pulli Peripheral vascular disco		Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown
Vital Rec		Completed by	Peripheral vascular disco Dementia 25. Was case referred to medical	10,	
5	ling Phys	ation: To Be	examiner? 1 Yes 2 No	of 28c. Injury at 28d. Desc	only one) Residence 6 □Other (Specify) cribe how injury occurred
DIVISION	i ji fi g	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	City o	tion <i>(Street and Number or Rural R</i> oute <i>Number,</i> or Town, State)
	To tha Hospitel or within 24 hours afte To tha Funaral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal can be dealered and manner stated. 29b. Signature and title of certifier	ath occurred at the time, date and place, and due to nvestigation, in my opinion, death occurred at the 29c. License number	time, date and place, and due to the cause(s)
	T W T		100mm (1)///0 mm	カファフタム	29d. Date signed (Month, Day, Year)
3	Ble		ANDREA ALLEN MO 2195. L	vashington St e	Easton mo 2/608
	Sta Registr		31. Date filed (Month, Day, Year) 32. Physistrar's Signature	parte	

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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Error	\cup	1	1	- 6	2	1	

		1- For State Registrar		ertificat	e of	Death			Re	g. No.	200	0 1333
Physicia	an/	1. Decedent's Name (First, Middle, L						2	2. Date of Deat Month	Day	Year	3. Time of Death
ledical Exami≀ /* ~	ner	Jessica Nico		_		b. City, Town, c	and another of	Dooth	June 17, 2	006	County of Death	1534 hrs
		Union Hospital	ive street and number)		1	Elkton	or Location of	Death			ecil	
Funeral		Social Security Number 6.	Sex 7. Age (In yr	s. last birthd	ay)	If Under 1 Ye	ear If Under	24Hrs.	8. Date of Birt	h(MM/D	D/YYYY) 9. Birth	
Director		214-29-7079	м ₂ х ғ 17		Yrs.	Months Da	ys Hours	Min.	Septemb	er 7	Foreign Cou	ntry) MD
		Usual Residence of Decedent										
w any		10a. State 10b. County	10c. C	ity, Town or	Locati	on						10d. Inside City Limits
daryland 28a-f show 1 at once.	to	MD Cecil		Elkto	on							1 Yes 2 X No
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number	- n.i			10f. Zip Code	1		10	-	en of What Coun	try?
ith the	_	1813 Nottingham	12. Was Decedent Ever in	1119 11	3 W/20	2192		n2 / Sne	cify Yes or No.	U.S	4. Race - Americ	on Indian Plack
items	Funera	1 XNever Married 2 Marri	ed Armed Forces?			es, specify Cuba					White, etc.	an mulan, black,
ther d	by Fu	3 Widowed 4 Divorc	1 Yes 2 X No ed If Yes, Give Year or Dates:		1	Yes 2 X N	lo specify:			s	pecify: Whi	te
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specify				's Usual Occupa				16b. Kir	nd of Business/In	dustry
36 in 72 h	ompleted	Elementary/Secondary (0-12) 11	College (1-4 or 5+)			-	0.00	30 10010	٥,	TJ-	ah Saha	.1
5-0036 led within 7. tygiene. other than the Medical	E	17. Father's Name (First, Middle, La	et)		otuc	dent	18 Mother's	Name (First, Middle, M		gh Schoo)T
21215-0036 total be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Charles J. Dvora	•				Lisa			iaidei i o	emane)	
2121 ould be fil d Mental Is s marked iic event,	2	19a. Informant's Name/Relationship		19b. I	Mailing	Address (Stre				ber, City	or Town, State,	Zip Code)
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once		Talmage L. Funk/	Grandfather	81	1 N	<u>Notting</u>	nam Rd					
5 2 E E E		20a. Method of Disposition 1 XBurial 2 Cremation 3		b. Place of to crematory	Disposi or oth	tion (Name of co er place)	emetery,		Date	20c. Lo	ocation - City or	own, State
Page ment tant:		4 Donation 5 Other Speci	ur Ur	nion (June	22,2006	Elk	tan, MD	
Baltimore, permit. Pages 1 an Department of Her Important: If ite	(21 Signature of Funeral Service Lic	ensee			ame and Addres		Fune	ral Hom	1 2		
Physician	4	23a. Part. Enter the disease, or cor	nplications that caused the de	ath. Do not e							21921	Approximate Interval
/Medical		failure. List only one cause on Immediate Cause (Final disease	each line. a. Methadone intox									Between Onset and Death
caminer		or condition resulting in death)	Due to (or as a consequence									
	Ļ	Sequentially list conditions,	b									
	nine	if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated	Due to (or as a consequence c.	е от):								
bs isi	Examiner	events resulting in death) Last	Due to (or as a consequence	e of):								
1760, ficate be executed g physician and the burial - transit		X UNPENDED	d. Xamended item#1	23a 27	280	-f,perME,	6857 77	/15/04	5 TTP			
760, ficate be e g physicia the buria	/Medical	IF FEMALE:	23c. If yes, outcome of pr		,200	r , perru,	,gos/,//	13/00) 11	224	Date of delivery	
587 reffica ling ph	an/h	23b. Was decedent pregnant in the past 12 months?	1 Live birth		Fet	al death 3	Ectopic	pregnand	су		Month D	ay Year
Box 68 e death certi the attending ed for use as	sician	1 Yes 2 No 9 ✔ Unknow	Pregnant at time of	5	Oth	er (Specify)				Î		
P.O. Box 687 s that the death cer fife greed by the att nding t edetached for use s ti	Phy	Part II. Other significant condition	9 Olikilowii	ot resultina ir	the u	nderlying cause	given in Par	t I	23e. Did to	bacco us	se contribute to t	ne cause of death?
ords, P.O. w requires that the second second properties of the second p	þ		3			,,	J					ably 4 🗸 Unknown
ds, requir	Completed								24a. Was a			opsy findings available
e law e has l	шb								autops	med?	death?	empletion of cause of
tal Recting the certificate ector, page		25. Was case referred to medical	1			26 Plac	ce of Death (C	Check on	1 Yes 2	2 N	1 🗸 Yes	2 No
Vital Rec hysician: The this certificate	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	✓ ER/Outp	atient		Other			Residen	ce 6 Other:	
n of V ding Ph.	-	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Tin	ne of In	jury 28c. Inj	ury at Work?	2	8d. Describe h	ow injur	y occurred	
ion trendi for: /	atio	1 Natural 5 Pending 2 Accident Investiga	Fnd 6/17/2006	Fnd :	2:45	pm 1 ⁻	Yes 2 _X	^{No} u	nk			
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be the both the funeral director, page 2 should be the funeral director.	Certification:	3 Suicide 6 X Could no	ot be 28e. Place of Injury - A	t home, farm	, stree	t, factory, office	building, etc.	. 2	8f. Location (S	treet and	Number or Run	al Route Number, City nam Road
Divis Hospital or 4 24 hours after Funeral Dire	Se	4 Homicide determine 29a. Certifier	(op cony)					JE.	Akton, M)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death cerdificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use, so the burn.	edical	(Check only Certifying Phys	ician: To the best of my knowler:On the basis of examination									
To To con	Mec	29b. Signature and title of certifier	and manner stated.				ise number				ate signed (Mon	
		Qual	*			0.0	.M.E.			June	18, 2006	
		30. Name and address of person wh	o completed cause of death (It	em 23a)								
			ant Medical Examiner		nn S	treet, Baltim	ore, MD 2	21201				
St Regist	ate	31. Date filed (Month, Day, Year) JUN 2 3 200	32. Registrar's Sign	ature do	sale							
Regist	للثاد	JOIN & 9 500	S PORTER SO	800								

1. Decedent's Name (First, Middle, Last) Tracy Eschenbur; 4a. Facility Name (If not institution, give) 907 Russell Ave 5. Social Security Number 6. Sc. 218-88-4688 Usual Residence of Decedent 10a. State 10b. County MD Wicomic 10e. Street and Number 907 Russell Ave 11. Marital Status 11. Marital Status 12. Never Married 2 Married 3 Widowed 15. Decedent's Ed. (Specify only highest grant Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Theodore R. Esch 19a. Informant's Name/Relationship (Theodore R. Esch 20a. Method of Disposition	ex 7. Age (In 43 Incomplete) 10. Was Decedent Ever Armed Forces? 1	Salisbu in U.S. 13.	Months Days Docation ITY 10f. Zip Code 21801 Was Decedent of His If Yes, specify Cubar 1 □ Yes 2 □ No dent's Usual Occupa	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 4/9/196	Day Year 7 2006 4c. County of D Wicomic Year) 9. 1 Og. Citizen of Whal USA 14. Race - A	beath CO Birthplace (State or F Country) MD 10d. Inside City I 1 □ Yes 2
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Theodore R. Esch 19a. Informant's Name/Relationship (7) Theodore R. Esch	henburo Sr	110		18. Mother's Nam	e (First, Middle, N	Own Home	
19a. Informant's Name/Relationship (7 Theodore R. Esch				Susan			
		19b. Mailir	ng Address (Street a			City or Town State	e Zin Code)
	anhura Cr	30,00					
·	20	D. Place of Dispo	2 01d Bri		Date 2	20c. Location - City	or Town, State
1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State		1 open Crei	' I	/2006	Frankfor	d DE
21, Signature of Fun ral Service Licen:			2. Name and Address				
Mr. Keek Bu	ulps.		108 Willia	am St.	Berlin. N	(D) 21811	nome
23a. Part1. Enter the disease, or composhock, or heart failure. List only of	olications that caused the c						Approximate
Immediate Cause (Final	one cause on each line.	- 0	. 1				Interval Betwee Onset and Dea
disease or condition resulting in death)	Due to (or as a con	sequence of	11015			-	> Cem
	0/00	من الم	Cic	chas	2 1		>lom
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence or):		1 1105	1 3		
Cause (Disease or injury that initiated events	C						
resulting in death) Last	Due to (or as a con	sequence of):					
	d						
IF FEMALE:							
23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy				
1 Yes 2 70	4☐ Pregnant at time 9☐ Unknown	of death 5 □	Other (specify)			Month	Day Year
Part II. Other significant conditions co	ontributing to death but not	roculling in the		- i- B - 44	00 - 011111		
0			idenying cause giver	nin Parti.			
C Sofricage	CJ Vaci	ices			1 L Yes	3 2 No 3 1	Probably 4 White
					autopsy	24b. Were a	autopsy findings avai o completion of cause
						ed? death:	/
25. Was case referred to medical examiner?	Haspital:	_	1		Check only one	L	
10 105	1Inpatient 2		1 3 DOA	4 Nursing Ho			pecify)
Natural 5 Pending	(Month, Day Year	r) Injury			28d. Describe hov	v injury occurred	
3 Suicide 6 Could not be		I home form stee			206 Longting (Ct.		
4 Homicide determined	building, etc. (Sp.	ecify)	eet, ractory, office		City or Town,	State)	Hural Houte Number,
29a. Certifier 1 Certifying Phy	Sician: To the heet of my	knowledge death	accurred at the time	date and place	and due to the re-		
(Check only 2 Medical Exami	iner: On the basis of exam and manner stated.	nination and/or inv	restigation, in my opin	nion, death occurr	ed at the time, dat	ise(s) and manner a e and place, and du	as stated. ue to the cause(s)
29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mor	nth, Day Year)
1013			110	0/127		1.1010	1
30. Name and address of person who or	ompleted cause of death (Item 23a) (Type F		2012	T	01010	عر
		nom zoa) (Type, P	11147				
Elleda G. Ziemer	n. D.O. 100	POWER CH	t., Salish	MA VALLE	21004		
F - 2	in the past 12 months? 1	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	and my, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	all any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C.	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C.	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Color Due to (or as a consequence of):	Cuse (Disease or injury hat midated events resulting in death) Last Color of the color of the

			1 - State of Maryland / Department Certificat	it of Health and Ne of Death		giene Reg. No.2 0 0 6	19933
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea	ath Day Year	3. Time of Death
	/Medi	cal	DOMENIC D. FORTINO 4a. Facility Name (If not institution, give street and number) 4b. City,	Town and proting of Dooth	JUNE	20 2006	6:10a ^M
1	Examir	ıer		Town, or Location of Death stertown	n	4c. County of Death Kent	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24 Hrs.	8. Date of Birt	h 9 Birth	place (State or Foreign
	Director		197-18-6395 1⊠M 2□F 80 Yrs. Months	Days Hours Min.	Apr 20		nsylvania
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryl f sho	for	MD Kent Galena				1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number 10f. Zip	Code		10g. Citizen of What Cou	ntry?
	th wit	aiD	13981 Mill Creek Lane 2	1635		U.S.A.	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flams 23a or 28a-f show ther, the Medical Examiner must be multiled at	by Funeral	1 Never Married 2 Married 1 Syss 2 No	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto 2 🗖 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
9	d within 72 hours piene. r than "natural", the Magical Exe	ed b	15. Decedent's Education 16a Decedent's Usua	al Occupation		16b. Kind of Business/Ir	
215	nin 72 In "ne Medis	Completed	(Specify only highest grade completed) (Give kind of wo life. DO NOT use	rk done during most of work se retired)	king	Tob. Kind of Business/in	austry
212	giene. er thar	E O	12 Plumber	:		Commerica	l Plumbin
nd	0 = 0 5	Be	17. Father's Name (First, Middle, Last)			Maiden Sumame)	
Maryland 21215-0036	문화환화	မ	Anthony Fortino			hardson	
Mai	12 s h ar 7 is trau		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Donna Dottellis (daughter) 13981 N	(Street and Number or Rui			
re,	1 a Heg		20a. Method of Disposition 20b. Place of Disposition (Nan	ne of	Date	20c. Location - City or Te	
Ë			1 XBurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Cemetery, crematory or of the state of		/23/06	Yeadon,	PA.
Baltimore,	artn orta inju		21. Significant of Funeral Service Library 22. Name an	d Address of Facility			
B	Depril mp		M00510 118 We	Funeral Fest Cross S	St. Gal	ena. MD.	L. Schaec 21635
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.	e of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Pnysician /Medical	M	Immediate Cavise (Final disease or condition resulting in death) a. ISCHEMIC (ARD)	10MYOPATH	ry		Onset and Death
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U.V. 19E			
	cuted nd ransit	Examine	that initiated events				
30,	oe exe		resulting in death) Last Due to (or as a consequence of):				
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9 xc	death certificate be executed e attending physicien and nd for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d Date of deliver	
Box	death e atter d for u	iciar	in the past 12 months? 1 Ves 2 No. 1 Ves 2 No. 1 Ves 2 No. 1 Ves 2 No.			23d. Date of delive Month	Day Year
P.0	t the by th ache	hys	9 ☐ Unknown 9☐ Unknown				
Vital Records, F	v requires tha been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying of	iuse given in Part I.	- 10	bacco use contribute to the es 2□No 3□Prob	_
ecc	law as b 2 s	Completed			24a. Was a		psy findings available mpletion of cause of
<u>=</u>	Th ate pag	Con			perform	med? death? 2.☑-No 1 ☐ Yes	2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
of	Phys r this ral dir	2	1 Inpatient 2 ER/Outpatient 3 DO			ence 6 Other (Specifi	y)
0	Attending r death. sctor: After by the fune	tlon	Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe fil	ow injury occurred	
Division	Atter octor by the	ifica	3 Suicide 6 Could not be		28f. Location (St	reet and Number or Rura	I Route Number,
ō	tal or	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Towr	n, State)	
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred a 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	it the time, date and place, in my opinion, death occurr	and due to the cared at the time, da	ause(s) and manner as st ate and place, and due to	ated. the cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and talle of certifier 29c.	License number		9d. Date signed (Month,	
ı			/ Withell of	006603	301	6(01(0)	Ь
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D A CI		WD 0100	
	Sta	te	Michael E. Peimer, MD. 122 Speer 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Rd. Cheste	rtown,	мр. 21620)
	Registr		JUN 2 3 2006 Research IX Grante				

			1 - For State Registrar	State of Ma	ırylan		artmen rtificate			and M	-	giene Reg. No.	2111	16	19	934
1.7	ş	×.	1. Decedent's Name (First, Middle, Last)								2. Date of De			-	3. Time	of Death
	Physici		ELISABETH	н т.		FUL'	TON				Month JUNE	Day 7	200	Year 16	2.1	2 P ^M
Marie Total	/Medi Examir		4a. Facility Name (If not institution, give s					Town. or	Location o	f Death	JUNE		County		J:1.	<u> </u>
	LAGITIII	101	9205 HOLLYOAK	DR.					HESDA						EDV	
	Funeral		5. Social Security Number 6. Sex		(In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Bir	th		CGOMI 9. Birtho	CKY place (State	or Foreign
	Director		579-46-2831 1 ¹	M 2XF	78	Yrs.	Months	Days	Hours	Min.	MARCH	7.19	28	Coun	MANY	or r orongin
	ס		Usual Residence of Decedent									,,15		OLIC	141111	
	how	١.	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside (City Limits
	e Ma	cto	MD. MONTGOME	RY			BETH	ESDA							1 X Ye	s 2 No
	th th	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of W	hat Coun	itry?	
	th w	a	9205 HOLLYOAK I	OR.				20	817				U. S	5.A.		
	dea	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	.S. 13. \	Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.))-	14. Race	- Americ	an Indian,	
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<u>a</u>	12 st h and 7 Is n traun		19a. Informant's Name/Relationship (Typ	,							l Route Numbe				Code)	
ص ک	fealth fealth im 2:	13	PETER FULTON/SO	N	20h D				DR.,		HESDA,					
Ö	る言言が		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re	emoval from State	200. F	lace of Disposementery, crem	atory or ot	e or her place)]	L	ate	20c. Lo	cation - C	ity or To	wn, State	
<u>E</u>	F I I I		4 □ Donation 15 □ Other (Specify)		CH	IAMBERS				-8-2			ERDA			
<u>a</u>	ermit epar npor ny in nce.		21. Signature of Funeral Service License	1		CH CH	Name and AMBER	Addres	s of Facility	, но	ME & CR	EMAT	ORTII	м.Р.	Α.	
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the death certificate be executed the second of the second			resulting in death)	Due to (or as a			KE									
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376	ate by	icai	d.													
3	ng ph	Med	IF FEMALE:													
õ	th ce tendi r use	an/I	23b. Was decedent pregnant 23	3c. If yes, outcome o 1□Live birth 2	f pregna		Ectopic pre	Mancy				2	3d. Date	of deliver	ry	
H	ed fo	Sici	in the past 12 months? 1 ☐ Yes 2 🔯 No	4☐Pregnant at ti			Other (spe						Monti	n 1	Day	Year
ت ت	at the	hy	9 Unknown													
- Ś	res that igned to be det	by	Part II. Other significant conditions cont	tributing to death but	not resu	ılting in the un	derlying ca	use givei	n in Part I.		23e. Did to	bacco us	se contrib	ute to the	e cause of	death?
Hecords,	w require been si should t										1 🔀 Y	es 2]No 3	☐ Proba	ably 4 🗆	Unknown
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Ĭ	: The law cate has page 2 s	E										med?	dea	ath?	npletion of a 2 No	ause of
Vital	sician: Th certificate irector, pag	0	25. Was case referred to medical						26. Place o	of Death	Check only o	2∭ No nel		1105	2 LJ 1NO	
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ָם בס	ng Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day	Vaari	28b. Time of Injury	28	c. Injury Work	at		8d. Describe h					
ō	Attending I death. ctor: After y the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Worth, Day	, oai,	iliquity	м		es 2 □ No	0						
DIVISION	- E - D	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur- building, etc.	y - At ho	me, farm, stre	et, factory,	office		2	8f. Location (S	treet and	Number	or Rural	Route Nun	nber,
5	s afte	Certification:		banding, etc.	(Specify	,					City or Tow	n, State)				
	To the Hospital or within 24 hours aft To the Funeral Di completely filled in	Medical	29a. Certifier 1X Certifying Physi (Check only one)	ician: To the best of er: On the basis of e and manner state	xaminat	wledge, death ion and/or inv	occurred a estigation, i	t the time in my opi	a, date and nion, death	place, a occurre	nd due to the d d at the time, d	ause(s) a	and mann place, and	er as sta	ited. the cause(s	3)
	omple omple	Me	29b. Signature and title of certifier	(1	\sim	29c.	License	number			29d. Date	signed (Month. D	Day, Year)	
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			30. Name and address of person who com		ith (item			LIOOP	ממ	CIT	TTE 100	D. T.	DITH 4.		MD ^	0017
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	al -	4a. Fecility Neme (If no	t institution, givi	e street and nun	nber)		4b. City.	, Town, or	Location of De					
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noral							If Unde	r 1 Year		rs. 8. Date				
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Physician Medical Examiner				10c. Cit	y, Town or Lo	ocation						100	I. Inside City Li	
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Department of Health and Mental Hygiene Rep No. 2 1. Department of Death 1. Department				1 ☐ Yes 2 💆										
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an H						16a. Dece	dent's Usu	al Occupa	ation		16b.	Kind of Bus	iness/Indu	stry
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i, i	ပ္	17. Father's Name (First	st, Middle, Last,)		DII	/С1		18. Mother's N	lame (First,			±	
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dete dete	든	Part II. Other significat	nt conditions	contributing to de	eath but not res	sulting in the u	inderlying	cause giv	en in Part I.	236	Did tobacc	o use contrit	oute to the	cause of deat
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			5 □ Pending	28a. Date (Mon	of Injury th, Day Year)		of	28c. Injun World	at	28d. De	scribe how in	jury occurre	d	
Director: A in by the fu	ertification	2 Accident 3 Suicide	investigatio	28e. Place					Yes 2 □ No	28f. Loc City	ation (Street or Town, Sta	and Number ate)	r or Rural F	Route Number
Funer ely fill	dicai C	(Check only 2	Certifying Pl	miner: On the b	asis of examina	owledge, deal	h occurred	d at the tin	ne, date and pla pinion, death oc	ice, and due ccurred at the	to the cause time, date a	(s) and man and place, ar	ner as stat nd due to ti	ed. he cause(s)
o th	Me	29b. Signature and title	e of certifier				29	c. Licens	number		29d. [Date signed	(Month, Da	ay, Year)
				10	2			000	1/290	18		6/0	6/0	90
-														
10		30. Name and address	of person who	completed caus	se of death (Ite	n 23a) (Tune	Print)		ا دیار					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0705 7, 2006 **Physician** June LOSSIE GAY /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 6, 1 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months 1 ☐ M 2 🖾 F 77 1929 North Carolina Director 241-40-5494 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "nature!, or iteme 23s or 28s-f show ury or other traumatic event, the Medical Examinar matter be notified at 1X Yes 2 □ No Forestville Prince George Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20747 2713 Boone Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Black, White, etc. 1 Never Married 2 Married **Black** 1 ☐ Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☑ Divorced 16h Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Social Worker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Whitehurst David Payton ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2713 Boone Lane; Forestville, Md. 20747 Guy Gay/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. Lincoln Memorial Cem. June 16,2006 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes 21. Signature of Funeral Service Licensee 20747 5538 Marlboro Pike; Forestville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heak-fatilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure, Pulmonary Emboli **Physician** /Medical Due to (or as a consequence of): Examiner Ovarian Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregu 2 Fetal death 3 Ectopic pregnancy Day Year ō in the past 12 menths? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should be Be Completed peeu Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 1No 1 ☐ Yes certificate or Attending Physician: 25. Was case referred dical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 ER/Outpatient 3 DOA 12 12 No 1 Inpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No s efter death. 2 Accident the 6 Could be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide in by 4 - Homicide To the Hospital within 24 hours e To the Funeral C pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 7, 2006 D0062969 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jay Shah, M.D. 104 Ridgely Ave. Suite 201 Annapolis, Md. 21401 Jay Shah, M.D. . Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 2 2006 Registrar

			1 - For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artmen <i>tificati</i>			and Me	-	giene Reg. No.	006	19939	
2. A.S.	Physicia	an	1. Decedent's Name (First, Middle, Doris Hawkins	Last)			_				2. Date of De June 4		Year	3. Time of Death 2:53 A M	
	/Medic Examin	-50	4a. Facility Name (If not institution,	give street and n	umber)		4b. City,	Town, or	Location o				unty of Deati		_
		,	Civista Medical		T =			ata,		0411		Char			_
	Funeral Director		5. Social Security Number 244–48–6752	3. Sex 1 M M 2 □ F	7. Age (In yrs	i. last birthday) Yrs.	Months	1 Year Days	Hours	Min.	8. Date of Bir (Month, Da 07-27-	th ly, Yea <i>r)</i> 1934	Co	hplace (State or Foreign untry) h Carolina	
,AT	pu *		Usual Residence of Decedent 10a. State 10b. County		100.0	ity, Town or Lo	cation							10d, Inside City Limits	_
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	death with the Maryland ms 23s or 28s-f show rinust be nutified at	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Co	•	_
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20	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or Items 23s or 28s-f show other than "natural", or Items 23s or 28s-f show seen, if a Medical Exactinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	Amed F d 1 Tes If Yes, G	orces? 21 No ive	'	f Yes, spec	rify Cubar	Specify:	i, Puerto R	Rican, etc.)		Black, White	e, etc.	
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7	filed v Hygie othar t	Be Co	8th 17. Father's Name (First, Middle, L.	ast)				-		r's Name	(First, Middle			Veriment	_
ylan		To B	Andrew Hawkins						Minn	nie D	eans				
maryiand	2 sh and ts n		19a. Informant's Name/Relationshi Vergina Hawkins			4211	og Address	(Street a	e Str	r or Rural	Route Number 104 20781	er, City or To	wn, State, Z	(ip Code)	
	s 1 and of Health Item 27 othar to		20a. Method of Disposition		20b.	Place of Dispo					20/01 ate		on - City or		-
saitimore,	Pages ment of ant: if it		1 Burial 2 Cremation 3			nesapeal	ke Cr	emat	$\operatorname{orv}^{\downarrow} 0$	6-10	-2006	Belts	ville,	, Maryland	
Dan	permit. Page Department of Important: if any injury or		21. Signature of Funeral Service Li	Consee Back	ou, cc	361 3	Name an 447 1	d Addres 4th	s of Facility Stree	t, N	W Wash:	ington	, D.C.	ne, Inc. . 20010	
			23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	omplications that nly one cause on	each line.				g, such as			rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a	(or as a conse	R Hosi	7		<u> </u>	- / \	00.	<u> </u>		171	_
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о П	0 0 2	Physici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Preg 9⊟Unk	nant at time of nown		Other (sp						Month	Day Year	
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ordi	w requires that s been signed b should be deta	ted t	ESOPHAGE/	+C	VARI	eEs PRos	- 4				10	Yes 2□N	o 3∏Pro	obably 4 Inknown	
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ē		O	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o		1 🗌 Yes	2 No	-
01	Physiclan: this certific ral director,	To B	examiner? 1 Yes 2 No			ER/Outpatien					e 5 Resi			ofy)	
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DIVISION	in Sign	Certification;	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	e of Injury - At ding, etc. (Spec	home, farm, str cify)	eet, factory	, office		28	8f. Location (: City or Tox		umber or Ru	ral Route Number,	-
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	To the I within 2: To the I complet	Med	one) 29b. Signature and title of certifier	and ma	nner stated.		290	. License	number			29d. Date si	gned (Month	. Day, Year)	
)	10) au	1		D-	-4443	36		3	Ju ME	04	2006	
(4)		30. Name and address of person washvin J. Patel					- C1	-0 10	9 17					
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sart.	Registr	ar	JUN 0 3 50	JO DE	De Jo	BOOM									

			1 - For State Registrar	State of Maryla			of Health			giene	006	19940
	1.0		Negistrar Decedent's Name (First, Middle, Last	st)					. Date of Dea	ath		3. Time of Death
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26	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, To	wn, or Location				ounty of Death	n
40			Holy Cross Hospi			Silver	Spring Year If Under	7			tgomer	
	Funeral		Social Security Number 6. S	ex 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Months [Year 1 If Under Days Hours	Min.	. Date of Birt (Month, Day	y, Year)	9. Birth	nplace (State or Foreign untry)
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	iand iand		10a. State 10b. County	10c. (City, Town or L	ocation						10d. Inside City Limits
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	r 28e	Director	10e. Street and Number	mery		10f. Zip C				10g. Citize	n of What Co	untry?
	23a o		1111 University B	lvdWest #1	311	2	20902			Jam	aica	
	dea E	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceder	nt of Hispanic Or Cuban, Mexica	rigin? (Specit in, Puerto Ric	fy Yes or No- can, etc.)	- 14	Race - Amer Black, White	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔼 No If Yes, Give		1 ☐ Yes 20					pecify:	
21215-0036	d within 72 hours after death with the Maryland jiene. Ir then "naturel", or Iteme 23e or 28e-f ehow the Modical Exacilizer must be notified at	D D	3 ☐ Widowed 4 ② Divorced 15. Decedent's Ed	Year or Dates:	16a Dece	edent's Usual (Occupation			16b Kind	Bla of Business/l	
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72	lane.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Certi	fied Nu	ırses As	ssista	nt	Hea1	th Car	e
Q	E STAN	0	17. Father's Name (First, Middle, Last)						First, Middle,	Maiden St	итате)	
lar	Aental Aental rked c	To E	Lloyd Henry					Anney	Coote			
Maryland	it. Pages 1 and 2 should be ritment of Health and Mental ritant: If Item 27 is marked in integrapher traumatic ev		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (5	Street and Numb	oer or Rural F	Route Numbe	er, City or 7	own, State, Z	(ip Code)
	and eatth n 27		Freddy Monfries	Cousin		llen St		Hemps			rk 11	
ore	T H T		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🗵		. Place of Disp cemetery, cre	osition (Name imatory or othe	er place)		1		tion - City or orelan	
Ë	tant:		4 □ Donation 5 □ Other (Specify		amily Co			Jun.10	,2006		Jama	P. Charles
Baltimore,	Depart mport any inj		21. Signature of Funeral Service Licer	1599			Address of Facil J. Coll					
	do I w G		23a. Part1. Enter the disease, or com	olications that caused the de	51 Do not en	00 Uni	rersity	Blvd.	W.,Si	lver	Spring	MD 20901 Approximate
8.			shock, or heart failure. List only	one cause on each line.						1001,		Interval Between Onset and Death
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	Examiner			Due to (or as a cons	equence or).							
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ó	te be executed ysicien and te burial-transit		resulting in death) Last	Due to (or as a cons	equence of):							
68760,		Ical		d								
39	death certifical e attending phy d for use as th	Physician/Med	IF FEMALE:									
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 Fe	etal death 3	⊒Ectopic preg				23	d. Date of deli Month	ivery Day Year
0	0 0 0	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	roeath 5	Other (spec	:пу)					
Δ.	\$ 8 B		Part II. Other significant conditions of	ontributing to death but not r	esulting in the	underlying cau	ise given in Part	I.	23e. Did to	obacco use	contribute to	the cause of death?
ds	uires sign td be	d by	Severe Anemia						101	/es 2□	No 3 □ Pro	obably 4 X Unknown
20	w requir been s should	ete							24a. Was	an	24b. Were au	topsy findings available
Records,	The lay ate has page 2	Completed								rmed?	prior to death?	completion of cause of
Vital			25. Was case referred to medical				26 Plac	e of Death /	1 ☐ Yes Check only o		1 🗆 Yes	2 No
\leq	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ※ No	Hospital: 1 Inpatient 2	☑ER/Outpatie	nt 3□ DOA	Othor				☐Other (Spec	cify)
J Of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time (of 280	o. Injury at Work?	28	d. Describe h	now injury	occurred	
Ö	Attending r death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident investigatio	n		М	1 ☐ Yes 2 ☐]No				
Division	- 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		t home, farm, s <i>icify)</i>	treet, factory,	office	28	f. Location (S City or Tox	Street and I vn, State)	Number or Ru	ral Route Number,
Ω	urs af rei D			4								
	Hospitel 24 hours 2 Funerel I	edical		nysician: To the best of my k miner: On the basis of exam and manner stated.								
	To the Hospitel of within 24 hours after the Funerel D completely filled in	Med	29b. Signature and title of certifier	and marrier stated.	٨	29c.	License number			29d. Date :	signed (Month	h, Day, Year)
	F 3 F 8			3 / Can	mp	D	50728			Tuno	1 2006	
	7		30. Name and address of person who	completed cause of death (I	tem 23a (Type		30120			Julie	1,2006	
	*		Thom B. Ramirez,				load Si	lver S	Spring,	MD :	20910	
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig								
eş.	Regist	rar	JUN 9 2	006 Janes.	15 14	KINGS OF						

			For State Registrar	State o	f Marylan	•	irtment of H		d Mental H	ygiene Reg. No.	ZIIIIh	19	942
	0.		1. Decedent's Name (First, Middle,	Last)					2. Date of D	Death	. Voor	3. Time of	Death
	Physicia /Medic		Mary N	Weather	оу На	rlan			JUNG	Death S ^{Day}	Zoo6	2:45	мД
	Examin		4a. Facility Name (If not institution,				4b. City, Town, or		Death	4c.	County of Death		
			Calvert Manor				Rising		Live III		Cecil		
	Funeral		5. Social Security Number 166-01-3174	5. Sex 1 □ M 2 K F	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, L	Day, Year)	9. Birth	place (State o	r Foreign
	Director	-	Usual Residence of Decedent		94				10-1	3-19	11		
	yland yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside C	
	e Mar	cto	PA Che	ster	T	oughk	enamon					1 □Yes	2 X №
	ith th	Director	10e. Street and Number				10f. Zîp Code			10g. Citi	izen of What Cou	intry?	
	ath w	rai	P. O. Box 30			0 1401	19374		0.00 7.17		USA	lana landian	
	er de Items	Funerai	11. Marital Status 1 Never Married 2 Marrie	Armed Fo		.S. 13. V	Yas Decedent of Hi Yes, specify Cuba	n, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	VO-	 Race - Amer Black, White 		
21215-0036	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show used Exambles i ust be notified at	by	3 ₩ Widowed 4 Divorced	If Yes, Giv Year or D	/0	'	☐ Yes 2☐ x No	Specify:			Specify: W	hite	
ŏ	72 hor	ted	15. Decedent's (Specify only highest				lent's Usual Occupa		- working	16b. K	nd of Business/li	ndustry	
21	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retired)	Working	10			
2	be filed within 72 hours after death with the Marylan nat Hygiene. Id other than "naturel", or litems 23e or 28e-f show event. It a Marcisal Examples or unit be notified at	Co		4\		Pair	nter	10 Marked	Name (First, Midd		ufactu	ring	
and	ntal H ad otl	Be	17. Father's Name (First, Middle, L Russell		cbv				lla Butl		Sumame)		
7	ges 1 and 2 should be it of Health and Mental If item 27 Is marked or or other treumatic ever	ဥ	19a. Informant's Name/Relationshi		- 4	19b. Mailin	a Address (Street a		or Rural Route Num		r Town, State, Zi	p Code)	
Ma	od 2 s Ith ar 27 is r treu		Lewis H. Ta			1			loughken				
ē,	ss 1 and 2 of Health item 27 I		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place		Date		cation - City or T		
Ę	Pages nent of int; If its iry or o		Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		State				6-12-06	Ker	nett S	quare	, PA
Baltimore, Maryland	permit, Page Department of Importent; If any injury or once.		21. Signatur Fun Sprvice &	cens	(a) (T)	22	. Name and Addres	s of Facility E	Edward L Pine St	. Cc	llins		al
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that of	caused the deat						TOLU,	Approximat Interval Bet	te
	Physician		Immediate Cause (Final disease or condition	1	1EWTIA							Onset and	
	/Medical		resulting in death)	a	(or as a conseq	juence of):							
	Examiner	<u>.</u>	Sequentially list conditions,	b	e	45							
	be.	Examine	cause. Enter Underlying Cause (Disease or injury	Due to	or as a cons	uence org							
	xecut and al-trar	xan	that initiated events resulting in death) Last	c. Due to	(or as a conseq	ruence of):							
8760,	icate be executed physician and s the burial-transit			d.									
9	tificat ig phy as th	ledicai											
Вох	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregna pirth 2 ☐ Feta		Ectopic pregnancy			:	23d. Date of delive	*	Year
0.	at the dea by the al tached fo	/sici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregr 9□Unkn	nant at time of d own	leath 5	Other (specify)					Duy	
Δ.	that the ned by detac		Part II. Other significant condition	s contributing to d	eath but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Dio	tobacco u	ise contribute to	the cause of c	ieath?
of Vital Records,	signe d be	d by	DIAROTES MIS	WITTS-T	YPE 2		, ,		1 🗆	Yes 2	No 3□Pro	bably 4 🗀	Jnknown
50	w require been si should t	lete	Conormy ARTE	inst Dist	217 1				24a. Wa	ıs an	24b. Were aut	opsy findings	available
Re	The lay	Completed	C0103-0-7 1710-1	1) 1) 30	73				per	topsy formed?	death?	ompletion of c 2 ☐ No	ause of
ta		a	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only		1 105	2 1100	
Ž	di is	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	t 3 DOA Othe	er: 4 X Nursi	ng Home 5□Re	sidence	6 □Other (Speci	ify)	
		J: T	27. Manner of Death Natural 5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injun Worl	at c?	28d. Describe	e how injur	y occurred		
Sio	Attendir death. ctor: Al y the fu	catle	2 Accident investiga	ation				Yes 2 □ No					
Division	N or Attending P after death. Director: After t d in by the funera	Certification:	3 Suicide 6 Could not determine determine	and 28e. Place	of Injury - At hing, etc. (Special	ome, farm, str fy)	eet, factory, office			(Street an own, State	d Number or Rui)	al Route Num	ber,
	pite ours ierel	edical Ce	29a. Certifier (Check only 2 Medical E	Physician: To the	best of my kno	owledge, death	occurred at the time	ne, date and p	place, and due to the	e cause(s)	and manner as	stated.	
	To the Hos within 24 h To the Fur completely	Medi	one)	and man	ner stated.		29c. License				e signed (Month,		
	To Wit		29b. Signature and title of certifier	^			1150	NIO			E 8, 200		
7	.7		30 Name and adding 1	to completed ac-	se of death /le-	n 23a) /Tuno	Print)	714		2014	0 0) 200		
	7		RODWEY DOWNAM	- > 10		SNAPH		sing Ju	N, MD 7	11911			
•	Sta	te	31. Date filed (Month, Day, Year)	32. F	Registrar's Signa								
	Registr	ar	JUN 1 2 2006	Blown	D. J.	your							

			1 - For State Registrar	State of Maryla		ertificate o			riene2006	19943
	Physici /Medic	al	Decedent's Name (First, Middle, Last BARBARA HUGHES					2. Date of Deal Month	OS O	
	Examin Funeral	er	4anFacility Name (If not institution, give Pen insula Regional 5. Social Security Number 6. Se	1 Medical C	en tel ers. last birthday			8. Date of Birth (Month, Day, 09-25-1	4c. County-of Dea	thplace (State or Foreign
	Director		213-42-2749 Usual Residence of Decedent 10a. State 10b. County	M 2☐ F X F 10c.	63 Yrs. City, Town or t		, 110010	09-25-1	942 BALT	10d. Inside City Limits
	h the Man or 28a-f sh	Director	MD WICOMI	CO	SALISB	URY	6	1	0g. Citizen of What C	1 XYes 2 No ountry?
9	BAITIMOFE, IMARYIANG Z1Z13-UU3O permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pyglene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show shiply or other traumatic event, the Medical Exeminar must be notified at once.	by Funeral D	727 CAMDEN AVENUE 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	n U.S. 13	. Was Decedent of If Yes, specify C	21801 of Hispanic Origin? (Speuban, Mexican, Puenco	ecify Yes or No- Rican, etc.)	USA 14. Race - Am Black, Whi Specify: V	erican Indian, te, etc. 7HITE
1	Baltimore, Maryland Z1Z13-UU30 semit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental hygiene. Theorient: if item 27 is marked other then "naturel," or may highly or other traumatic event, the Medical Examinate.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation	(Giv life.	DO NOT use rei	ne during most of work	ing	16b. Kind of Business	Vindustry
-	aryland Z should be filed and Mental Hygis s marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) HARRY WILLIAM KRA	HN, JR.			18. Mother's Nam	HERINE Z	Maiden Sumame)	
:	C, Mar 1 and 2 sh 1 ealth and 1 m 27 is m 1 hsr traum		19a. Informant's Name/Relationship (T) THOMAS J. HUGHES 20a. Method of Disposition	- SPOUSE	727	•	VENUE, SAL	ISBURY,		21801
	ILIMOT iit. Pages triment of to ortent: If its injury or of		1 □XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	cemetery, cre	MEM. PA	olace)	2-2006 S	ALISBURY,	MARYLAND
(Depariment of the control of the con		23a. Part. Enter the disease, or composic, or heart failure. List only	my Black	0 7	05 EAST	MAIN STREE	T,SALISE	URY,MARYLA	ND 21804
•	Physician /Medical Examiner		sy ck, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. SEPSI a Due to (or as a cons	ς					Interval Between Onset and Death DAYS
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of):					
	od rou, icate be executed physicien and s the burial-transit	cai	resulting in death) Last	Due to (or as a cons	sequence of):					
400	VISION OT VITAL MECONDS, P.O. BOX OS Attending Physician: The law requires that the death certifical relath. sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pregna □ Other (specify,			23d. Date of de Month	livery Day Year
	rdS, F quires that an signed b	ed by PI	Part II. Other significant conditions co		resulting in the	underlying cause	given in Part I.		pacco use contribute to es 2 □ No 3 □ P	o the cause of death?
5, 13	II MECO The law re sete has bee page 2 sho	Completed	ANEMIA O	F CHRUNI				24a. Was an autops perform		utopsy findings available completion of cause of 2 17 No
MUGHES,	DIVISION OF VITAL RECORDS, To the Hospital or Attending Physician: The law requirest within 24 hours eiter death. To the Funeral Director: After this certificete has been signe completely filled in by the funeral director, page 2 should be	To Be	27. Mannes of Death	Hospital: 1 DInpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatie		26. Place of Deat Other: 4 \(\text{Nursing Ho} \) Nury at Nork?	me 5□Reside		cify)
1	JIVISION or Attending siter death. Director: Atte	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	(Month, Day Year 28e. Place of Injury - A building, etc. (Spe	it home, farm, s	M 1	□Yes 2□No	28f. Location (St. City or Town	reet and Number or R	ural Route Number,
(To the Hospital o within 24 hours ef To the Funeral Di completely filled in	Medical Cer	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my liner: On the basis of exame and manner stated.	knowledge, dea ination and/or i	ith occurred at the	e time, date and place, by opinion, death occur	and due to the ca	use(s) and manner a ate and place, and due	s stated. s to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				ense number		9d. Date signed (Mont	
	109/2		30. Name and address of person who co			, Print)	UN SUITE		SURY MO	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Si		1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician JACKSON** MATTHEW BURTON P 06 3 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□ F 226-28-9946 81 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location injury or other traumatic event. It is Medical Exactinat must be notified at e. 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director SilverSpring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U.S.A. 10 Beechvue Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural", or iter any injury or other traumatic event. Its Medical Esertirat once. 1 MYes 2 NoWWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: Black δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) American Elementary/Secondary (0-12) College (1-4or 5+) University Technician 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George J. Jackson Verlena Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Beechvue Ct Silver Spring, MD 20906 Shelly Moorefiled- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Kurial 2 ■ Cremation 3 ■ Removal from State 4 Donation 5 Other (Specify) 6/10/06 Silver Spring, MD of Heaven Gattel 21. Signat rex: Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or comblications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to initial secures. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of the attending physicien and ched for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ¯ 2 ER/Outpatient 3 DOA မှ filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06-0306 D0060100 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TH (MINH WA)

Gram Completed Cause of death (Item 23a) (Type, Print) MD 7600 CARROLL AVE TAKOMA PARK, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 9 2006 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Beverley T. Jones 2006 UNG 10 2300 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONIX MEDIENE SHIBAS Nicomico PENINSULA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 70 Director 218-34-9133 Sept. 11, 1935 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 10d. Inside City Limits 1-X Yes 2 No Director MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Liberty Way 21826 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 MYes 2 No If Yes, Give Korean Year or Dates: War 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 XX Divorced White War Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Manufacturing Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be f h and Mental H R. Alda Jones Mary Cash Pages 1 and 2 shoument of Health and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele D. Stant (Daughter) 424 S. Church Street Snow Hill, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Depertment of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 06-11-2006 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove St. D 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heav failure. List only one cause on each line. Vewell Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Klebsic Ila 10 days 500515 /Medical Due to (or as a consequence of): **Examiner** plestic month, anemia Sequentially list conditions, any leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit certificate be executed Males man.

Due to (or as consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Ö certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 00 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes of Vital After this certifice a funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 200 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division 1 Natural 5 Pending Injury death. м 1 ☐ Yes 2 ☐ No 2 Accident investigation or Attend after death Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and ottle of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.O June 11, 2006 030690 IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN M.O. James E 145 E. Grall St., Solisbury, MD 21801 31. Date filed (Month, Day, 32 Registrar's Signature Yeart State 2006 Charles Land Registrar

218-34

			1 - For State Registrar	State of Ma	ıryland		artmen <i>rtificat</i>			and M	•	giene Reg. No.	2006	19946
	Physici		1. Decedent's Name (First, Middle, Last)	Dorothy	Ann	Koc	ns				2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give str. 5802 Corpover Road					Town, or eyto	Location o		June		2006 County of Death arroll	10:26 P [™]
	Funeral Director		5. Social Security Number 215–34–2285 Usual Residence of Decedent	7. Age	70	t birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bir (Month, Da Nov. 2.	th ly, Year) 2 , 1 9	9. Birth Cou 35 Mary	place (State or Foreign ntry) land
	r 28e-f show	tor	10a. State 10b. County Maryland Carroll		10c. City, T	own or Lo								10d. Inside City Limits 1 ☐ Yes 2X No
	with the le or 28	Direc	10e. Street and Number 5802 Conover Road				101. Zip	Code 787				-	en of What Cou	•
336	72 hours after death with the Maryland neturel', or items 23e or 28e-f show deal Examinar must be neitled at	by Funeral Director		Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:		1		lent of His	spanic Origin, Mexican	gin? (Spe i, Puerto i	cify Yes or No Rican, etc.)	- 1	4. Race - Ameri Black, White, Specify: Wh	can Indian, etc.
Maryland 21215-0036	a within 72 hou piene. Ir then "neture the Medical E	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)			(Give life.	dent's Usua kind of wor DO NOT us	rk done d e retired)	u <i>ring m</i> ost		ng		d of Business/Ir	dustry
land 2	be filed Ital Hyg Id othe event,	To Be Co	12 17. Father's Name (First, Middle, Last) Herman Hartsock		1_	5111	pping	Tea	18. Mothe	r's Name	(First, Middle,	Maiden :	101 -	
	and and is m		19a. Informant's Name/Relationship (Type Lori J. Bare / dai				ng Address Cono		_				Town, State, Zip ryland	
nore,			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Ren		cem	etery, crei	osition (Naminatory or of	ther place		June	ate 22	20c. Loc	ation - City or To	own, State
Baltimore,	permit. Page Department of Importent: If eny injury or once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Di.	GLAC	22	2. Name an	d Addres	s of Facility	y Sk	2006 iles Fi Street	mera	1 Home	Maryland MD 21787
The state of the state of	Fnysician /Medical Examiner	ıer	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying and a sequential should be supported by the sequential should be sup	tions that caused cause on each lin CAU Due to (or as a	e. CER a consequen	ce of):				cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
68760, <	ifficate be executed g physician and as the burial-transit	edical Examine	cause. Enter Onderlying Cause (Lieuwer of Flying that initiated events resulting in death) Last d	Due to (or as a	ı consequen	ce of);								
.O. Box	at the death certificate by the attending phys tached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal de	ath 3[Ectopic pro					2:	3d. Date of delive Month	ery Day Year
rds, P	signed signed d be de	leted by Pł	Part II. Other significant conditions contri	buting to death bu	t not resultir	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did to		e contribute to ti No 3 ☐ Prob	ne cause of death?
Vital Records,	The law ate has b page 2 sl	Complet									24a. Was autor perfo 1 \(\text{Yes} \)		prior to co death?	psy findings available mpletion of cause of
of	Attending Physicien: 1 r death. ector: After this certificat by the funeral director, p	atlon; To Be	TE Tes ZVINO	pital: 1 Inpatier 28a. Date of Injun (Month, Day	nt 2□ER y Year) 28	Outpatier b. Time of Injury		Bc. Injury Work	r: 4 🗆 Nui	rsing Hon 2	(Check only one 5 side side state of the sta	dence 6	☐Other (Specifi	у)
Division	in Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At home . (Specify)	, farm, str	eet, factory	, office		2	8f. Location (S City or Tox	Street and vn, State)	Number or Rura	l Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filted in by	edical C	29a. Certifier (Check only one) 1. Certifying Physic 2 Medical Examine	ian: To the best or: On the basis of and manner state	examination	dge, deatl and/or in	n occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, a	nd due to the d at the time,	cause(s) a date and p	ind manner as si place, and due to	tated. o the cause(s)
)	To the To the comp	Me	29b. Signature and title of certifier	5		P. 2 -	29c	License	number 386	46-	L	29d. Date	signed (Month,	Day, Year)
	15			マウハ とり	- la	9	Print)	n.K	رماد	21	tt les	ton	IN PA	Day, Year) 17340
:	Sta Registi	-	31. Date filed (Month, Day, Year) JUN 2 3 2006	32 degistra	r's Signature	The same of the sa	net s							

			1 - State of Maryland / Department of Health a Certificate of Death	ind M	ental H	ygier Reg. I	an U	06	9	947
ı	Physici		1. Decedent's Name (First, Middle, Last) William Gerald Kittle		2. Date of Month June		Day 20	Year 006	3. Time (
	/Medic Examin			f Death	0000		4c. County Carre	of Death	12.20	
	Funeral Director		5. Social Security Number 217–40–4034 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 2 Months Days Hours	Min.	8. Date of (Month, Sep.	3irth Day, Yea	1944	9. Birthi Cou	olace (State ntry) Virg	or Foreign inia
	death with the Maryland ms 23a or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Carroll Taneytown						10d, Inside (City Limits
	h with th	al Director				_	Citizen of t		•	
036	o 72 hours after death with the Maryla "natural", or Itams 23a or 28a-1 show "dical Examinat be nutified at	by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1964 1 ☐ Yes 2 ☐ XNo Specify:	in? (Spec , Puerto F	cify Yes or Rican, etc.)	No-	Bla	ce - Americk, White,		-
9500-6121	withir han	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	of workin	g		Kind of B		•	
/land 2	be filed stal Hyg od otha event,	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)		(First, Midd					
Mary	ts or E. E.		19a. Informant's Name/Relationship (<i>Type, Print</i>) Marjorie Ellen Kittle / wife 132 West Baltimore						Code) • 2178	37
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar fra		20a. Method of Disposition 20b. Place of Disposition (Name of	June	ate	20c.	Location -	City or To		
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 136 East Baltimo	Ski	les Fu	ner	al Ho	me	Md. 2	
	Physician /Medical Examiner	ler	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			arrest,			Approxima Interval Be Onset and	tween
> ,09/80	flicate be executed g physician and is the burial-transit	dicai Examine	resulting in death) Last Due to (or as a consequence of): d.					and the		
O. Box b	the death certi y the attending iched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 5 Other (specify) 1 1 1 1 1 1 1 1 1					te of delive		Year
cords, r	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				use cont		ne cause of	
ı L	The far ate has page 2	Completed			24a. Wa aut per 1 🗆 Yes	opsy formed?			psy findings mpletion of c	
T VITAL	rysician nis certifi director	To Be	examiler:		Check onl		6 □Oth	er (<i>Specif</i>)	()	
DIVISION OF	To the Hospital or Attanding Physicien: Within 24 hours after death. To tha Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 4 Natural 5 Pending (Month, Day Year) 4 Natural 5 Pending (Month, Day Year) 5 Natural 7 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 2 Natural 1 Pes 3 Natu	28	Bd. Describe					
2	ital or Att		4 Homicide determined determined building, etc. (Specify)		City or T	own, Sta	ite)		I Route Nun	nber,
	tha Hosp in 24 hou tha Fune inpletely fi	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, ar occurred	nd due to th	e, date a	nd place, a	and due to	the cause(s	s)
	To with	Σ	29b. Signature and title of certifier ADPLD D006104	0					Day, Year)	26
	10 11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Bal	timor				,	***
Ì	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 3 2006 32. Restaurar's Signature			-	_			

Please Type or Print in Black Indelible Ink

Steven S. Kerrick	S 1- For State	tate of Marylar	nd / Departm <i>Certific</i>			Mental		21	ins leak
Physician/	Registrar 1. Decedent's Name (First, Midd	dle,Last)					2. Date of Dea	Reg No C	3. Time of Death
Medical Examiner	Steven Scott						Month June 5, 2	Day Year 006	1132 hrs
gram.	4a. Facility Name (if not instituti	on, give street and num	ber)	4b	. City, Town, or L	ocation of D		4c. County of I	Death
	17900 Dumfries Circl	е			Olney			Montgome	ry
Funeral	5. Social Security Number	6. Sex 7	. Age (In yrs. last bir	thday)	If Under 1 Year	If Under 2			9 Birthplace (State or
Director	510 52 5226	1 X M 2 F	53	Yrs.	Months Days	Hours	Min.	9,1952	Foreign Country)
	519-52-5236 Usual Residence of Decedent						TDec. 2	9,1952	Idaho
any	10a State 10b. County		10c. City, Town	or Location	١				10d. Inside City Limits
ž .	Maryland Mont	gomerv		01ne					1 Yes 2 X No
arylar 8a-f s at on	10e Street and Number	gomery		OTILE	10f. Zip Code			10g. Citizen of What	Country?
ith the Maryland 23a or 28a-f show notified at once. al Director	1770/ 01-1- mt	t				00000	.		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygene 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	17704 Globe Th		dent Ever in U.S.				(Specify Yes or No		American Indian, Black,
er death with t , or items 23s r must be not Funeral	1 Never Married 2 X	Armed For		If Yes	, specify Cuban, i	Mexican, Pu	erto Rican, etc.)	White, e	itc.
fier de l'. or ler mi	3 Widowed 4 D	vorced If Yes, Give Year or Dates:	1985 006	1 1	es 2X No	specify:		Specify:	White
tural" amine	15. Decedent's Education (Sp	ecify only highest grade	completed) 16a.		Usual Occupation			16b. Kind of Busin	
72 hc al Ex	Elementary/Secondary (0-12) College (1-4	4 or 5+)	auring mos	t of working life. [JO NOT use	e retirea)		
5-0036 ed within 72 hour tygiene other than "natu the Medical Exau Completed		5⊣	- (phtha	lmologis	st		Media	ea1
5-0036 Jed within 7 Hygiene I other than the Medica	17. Father's Name (First, Middle	e, Last)			18	3 Mother's N	lame (First, Middle,	Maiden Surname)	
2121: ould be fil Mental I marked c event,	Charles Ellsw	orth Kerric	k			Patri	a Olese		
D 21 should and Mer 7 is man ratic ev	19a. Informant's Name/Relation			_	,			mber, City or Town,	
ME 2 south an 27 aums	Mary Susan Hoe 20a. Method of Disposition	<u>ffer Kerric</u>	k Wife	7704	Globe Th	neatre	Drive (Olney, Mary	zland 20832
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by I	1 Burial 2 X Crematic	on 3 Removal from	n State crema	of Dispositi	on (Name of ceme r place)	etery,	Date	20c. Location - Ci	ty or Town, State
Baltimore, permit Pages I an Department of He Important: If ite injury or other trees injury or other trees in the Institute of the Institute of the Institute or other trees in the Institute	4 Donation 5 Other S	Specify:	Metrop	olita	n rematory	, J	un. 14. 200)6 Alexand	lria,Virginia
Balti Bermit Departm Imports injury	21. Signature of Funeral Service	e Licensee	-	22. Na	me and Address of	of Facility			
. m 8'9 e 's	Mohen	Lolo		500	Univers	sity B	1vd.,W.,S	Silver Spr	Inc. ring.MD 20901
Physician	23a. Part I. Enter the disease, of failure. List only one caus		used the death. Do r	ot enter the	mode of dying, s	uch as card	iac or respiratory ar	rest, shock, or heart	Between Onset and
/Medical Examiner	Immediate Cause (Final diseas								Death
	or condition resulting in death)	Due to (or as a c	consequence of):						
1	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):						
nine	cause. Enter Underlying Caus	е	2011004401100 017.						
ed nsit Examiner	(Disease or injury that initiated events resulting in death) Last		consequence of).						
and trans		d							
0, e be executed rsician and burial - transit edical Ex	UNPENDED	AMENDED							
76C icate i phys the by	IF FEMALE: 23b. Was decedent pregnant in		utcome of pregnancy			Te mais as		23d Date of de	
ox 6876/ auth certificate attending phy or use as the the sician/M	past 12 months?	LIVE DI	-1 -4 45 40 046	- =	I death 3 _ er (Specify)	Ectopic pr	egnancy	Month	Day Year
Box e death of the atter ed for us	1 Yes 2 No 9 U	nknown 9 Unknov		J Othe	y (Specify)			Ť	
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phyterral director, page 2 should be detached for use as the on: To Be Completed by Physician/M	Part II. Other significant cond	itions contributing to	death but not resulting	ng in the un	derlying cause giv	ven in Part I	23e. Did	tobacco use contribu	ite to the cause of death?
P.(es that igned be det							1 Ye	es 2 🗸 No 3	Probably 4 Unknown
Records, The law require ficate has been signing a spage 2 should b.							24a. Was		ere autopsy findings available
COF law I has b								ormed? dea	or to completion of cause of ath?
Re The Cor					00.01	- f D 11- (O)	1 Yes	2 No 1	Yes 2 No
icerti Be	25. Was case referred to medic examiner?	Linewitch	patient 2 ER/0	Outpatient		Hhor -	neck only one)	Residence 6	Other Cases
of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should n: To Be Completed	1 Yes 2 No 27. Manner of Death			. Time of Inj				how injury occurred	
Division of V spiral or Attending Ph. iours after death neral Director: After ti filled in by the funeral Certification: T.	1 Netural	28a. Date of (Month)	Day, Year) FO	UND:		es 2 V No	Subject sta		
Siol Atten death ector:		estigation Jun 5, 20	of Injury - At home,	25 hrs			-72	(Street and Number	or Rural Route Number, City
Division tal or Attendii Ta for Attendii al Divector: A led in by the for	de	uld not be termined (Specify)		iaiii, street	, ractory, office bu	manig, etc.	or Town,	State)	
6 - 5	4 Homicide	(,		anth accom	od at the time = = -	o and site		nfries Circle Driv	
he Ho in 24 he Fu pletel		Physician: To the best caminer:On the basis of	от my кnowledge, d f examination and/or	eam occurre investigation	eu at the time, dat on, in my opinion,	e and place death occur	, and due to the cau red at the time, date	ise(s) and manner as and place, and due	started. to the cause(s)
To the Ho within 24 within 24 completed	29b. Signature and title of certi	and manner sta	ated		29c License				(Month, Day, Year)
15+11=	1 n-				O.C.M			June 6, 2006	
/~ /	Yamete Tou	thall, MD			J. 5.5.1V			34.10 0, 2000	
	7	on who of mpleted cause Assistant Med	e of death (Item 23a) dical Examiner		enn Street, Ba	altimore	MD 21201		
2.17	Pamela Southall, MI					and note;			
State Registra		2006	strar's Signature	Popular	West of				

Registrar

	1	State of Maryland / Departs Cert	rtment of Health and M tificate of Death	ental Hygiene Reg. No	2000 19330
Physici	an	1. Decedent's Name (First, Middle, Last) Gerald Lee Lyon		June 6,	3. Time of Death 2006 15:49 M
/Medio Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	44	c. County of Death Anne Arundel
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 229–66–4854 12 M 2 □ F 58 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year Oct 8, 194	9. Birthplace (State or Foreign Country) Virginia
•how	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc MD Anne Arundel Harwood	ation		10d. Inside City Limits 1 ☐ Yes 2 💆 No
h the M or 28a-1	irect	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
ath wit	raiD	4775 - G Carmody Ct	20776	ocifu Vas or No	USA 14. Race - American Indian,
hours after de urai', or items	by Funeral Director	1 XI Never Married 2 Married 1 Yes 2 XI No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☐ Yes 2X No Specify:	Rican, etc.)	Black, White, etc. Specify: White
ife, IMBIVIGATO ZIZID-UUJO s 1 and 2 should be filed within 72 hours after death with the Maryland lifeath and Mental Hygiene. tiem 27 is marked other than "natural", or items 23a or 28a-1 ehow other traumatic event, the Medical Examinational be notified at	Completed	(Specify only highest grade completed) (Give kilder) Flementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation kind of work done during most of worki NO NOT use retired) ds Maintenance	ng	kind of Business/Industry
Fight A	To Be Co	17. Father's Name (First, Middle, Last) Thomas H. Lyon	18. Mother's Name	· Godfrey	
Maryia d 2 should I d 2 should I th and Men th and Men traumatic		-004	g Address (Street and Number or Rura Woodland Road Po		or Town, State, Zip Code) 20675
MOTE, IN Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 20b. Place of Disposition cemetery, crem		12 20c. I	ocation - City or Town, State
Baltimor permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Le B125 Southern Mary	e Funeral	Home Calvert, PA
Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition	er the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	repholyethy	6	munts
760, le be executed ysician and le burial-transit	Examiner	ff any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	/ / /		
68760 ilicate be e g physiciar as the buria	dicai	d			
BOX ath cert attendin	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
'ds, P.O. I	b	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records, The law requires tate has been signe	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
Vital F sician: Th certificate	Be	25. Was case referred to medical examiner? Hospital Inspirate 2 FB/Cutestage	Other	h (Check only one)	6 Other (Specify)
Phys this	ıtlon: To	1 Yes 2 No Inpatient 2 ER/Outpatien 27. Manner of D. Ith 1 Natural 5 Pending investigation 28a ate of Injury (Month, Day Yeer) 28b. Time of Injury Injury		28d. Describe how inj	
Divisi	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, strubulding, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Division of the Hospital or Attanding within 24 hours after death. To the Funaral Director: After completely filled in by the funaral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medicel Examiner: On the basis of examination and/or invariant planner stated.	vestigation, in my opinion, death occur	red at the time, date a	nd place, and due to the cause(s)
To t within To t	2	29b. Signature and tipe of certifier	29c. License number	1 6	late signed (Month, Day, Year)
10		30. Name and address of person who completed cause of death (Item 23a) (Type,	10 Holado	1 Melic	I conten
S Regis	tate trar	31. Date filed (Month, Day, Year) - 32. Registras Signature JUN 1 2 7 106	Sporte		

			For State Registrar	State of	Marylan				d Mental H	ygiene Reg. No. 🤈	000	1005
S.	Physici /Modic	1 - State Certificate of Death Reg. Certificate of Death Reg. Certificate of Death Reg. Certificate of Death Certificat	eath Day	Year 2006	3. Time of Beath							
•	Examir	1.04				ER			eath	4c. Cou	nty of Death	
.344	Funeral Director		5. Social Security Number 6. Sex 213-22-4668	7	. Age (In yrs.	last birthday)	If Under 1 Yo	ear If Under 24	Hrs. 8. Date of B	irth Day, Year)		
	death with the Maryland me 23s or 28s-f show I must be notified at	ctor	10a. State 10b. County	:o	10c. Cit						10	d. Inside City Limit
etor	th with th	ai Dire								10g. Citizen d	of What Count A	γ?
F.9	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hyglene. If Item 27 Is marked other than "neturel", or Iteme 23a or 28a-f show or other traumatic event, It a Madical Evantinal must be notified at	þ	1 Never Married 2 Married	Armed Ford 1 ☐ Yes 2 If Yes, Give	ces? 2 🖄 No	31	Yes, specify (Cuban, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	Spec	lace - America lack, White, e	
1215-003	within 72 hor ene. then "neture ne Medicel I	mpleted	(Specify only highest grade	completed)	4or 5+)	(Give life. L	kind of work do OO NOT use re	ne during most of	working		Business/Indu	•
Mand 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic avant, tra Ma	Be	17. Father's Name (First, Middle, Last)			cas	nier				ery Sto	re
Many	and 2 should salth and Men n 27 Is marke ler traumatic											Code)
$\mathcal{L}_{\mathcal{O}\mathcal{D}_{\mathcal{O}_{\mathcal{L}}}}/\mathcal{N}_{\mathcal{O}_{\mathcal{O}_{\mathcal{C}}}}$ Baltimore, Maryland	Pa me Pa		1 DABurial 2 □ Cremation 3 □R	emoval from Si	tate	emetery, cren	natory or other	place)			n-City or Tow	
Balt	permit. Departr Importa sny Inje		21. Signature of Funeral Service Lione	energ	CESF	2 H	olloway 01 Snow	Funeral Hill Rd	Home Pro	ofession oury, MI	nal Ass 0 21804	ociation
· · · · · · · · · · · · · · · · · · ·	Physician / Medical physician and physician	Ilcai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a consequence of as a consequence	uence of):	(0.		allest,	1	Approximate Interval Between Onset and Death
P.O. Box 6	Physician: The law requires that the death certific this certificete has been signed by the attending p rai director, page 2 should be detached for use as	hysician/Mec	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq 12 \) No	1□Live birt 4□Pregna	th 2 ☐ Feta nt at time of d	I death 3					Date of delivery Month E	y Day Year
rds, P	w requires that been signed t should be deta	۵	Part II. Other significant conditions con	tributing to dea	ath but not res	ulting in the ur	derlying cause	given in Part I.			_	cause of death?
al Reco	n: The law re licete has be r. page 2 sho								— auto peri 1 ☐ Yes	2 No	o. Were autops prior to com- death? 1 \(\text{Yes} \) 2	sy findings available pletion of cause of
Division of Vital Records,	or Affe	유	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of (Month,	Injury , Day Year)	28b. Time of Injury	28c. I	Other: 4 Nursin	g Home 5 Res	how injury occ	urred	
Divi	pital or Attendi iurs after death. eral Director: A illed in by the fu		4 Homicide determined	<u> </u>					City or To	iwn, State)		
	To the Hospital within 24 hours of To the Funeral Completely filled	Medica	one)	er: On the bas	sis of examinat	wledge, death tion and/or inv	estigation, in n	y opinion, death o	ace, and due to the occurred at the time	cause(s) and r , date and place 29d. Date sign	e, and due to t	he cause(s)
	B		30. Name and address of person who con	mpleted cause	of death (Item	1 23a) (Type, f	Print)	299	7	4/8/	82	
	Sta Registr			32. B	gistrar's Signa		SALISB	URY, MD.	21804			

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Hygiene	2	0	0	5	Brown and	9	9	5	2
72-711 2911									

	•	1 - For State Registrer	State of Mic	aryland / Depa <i>Ce</i>	rtificate of		rentai mygie Reg	-	JUb	19902
oioio		1. Decedent's Name (First, Middle, Las	1)				Date of Death Month	Day	Year	3. Time of Death
sicia edic		Betty Eileen	May				06	30	06	13,35 M
mine	er	4a. Facility Name (If not institution, give				Location of Death			ty of Death	
		WMHS- Braddoc				If Under 24 Hrs.		AW	egan.	
ral tor		5. Social Security Number 6. Se	□M 2F0FF	(In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y			place (State or Foreign ntry)
.01		196-18-0998 Usual Residence of Decedent		82 Yrs.	i		Nov 2,1	923_	Penn	sylvania
		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	to	Maryland Alle	gany	Frostbu	ırg					1 ☐ Yes 2 ☐ No
	lre	10e. Street and Number			10f. Zip Code		10g	. Citizen o	What Cou	ntry?
	<u>a</u>	100 Honeysuckle	Lane Ap	t 105	21532	2		USA		
	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americack, White,	
		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☐ No	Specify:		Spec	ihe:	ite
	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup kind of work done	ation during most of worki	ng 16	b. Kind of	Business/In	
	g l	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired Homemak e			Or.7:	n IIon	
×	ပိ	17. Father's Name (First, Middle, Last)			JOINEMANE		e (First, Middle, Mai		n Hon	ie
	Be	_	Tourown					oen oune	ine,	
	ဍ	George Raymond 19a, Informant's Name/Relationship (7)		19b. Mailiu	na Address (Street)	Irene	LOWERY al Route Number, C	ity or Tow	n State Zin	Codel
0		Carol Jenkins-	,, ,				ale, MD			2000)
		20a. Method of Disposition		20b. Place of Dispo			Date 200		- City or To	own, State
		1 ∰Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Cooks M		TO COLLE	22,2006 I	Hyndi	man,	PA
buce		21. Signature of Funeral Service Licen	(() (Name and Address Hafer Fu	C		T) 3		
		23a. Parta Enter the disease, or compshock, or heart failure. List only	plications that caused	the death. Do not ent	1302 Nat	ional H	wy LaVa	ale,	MD 2	1502 Approximate
		shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	e. C	Varcular	- (1)	let			Interval Between Onsetjand Death
an al		disease or condition resulting in death)	a		hortonor!	acci				2/204/3
er			Due to (or as a	consequence of):	in -					7 1 1416
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):		()				Divers
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):	in Nest	t tail	w(e			geog
			d Due to (or as a	consequence or).						
	edical	-	u							
	2	230. Has decedent program	23c. If yes, outcome of		Ectopic pregnancy			23d. D	ate of delive	ry
	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Other (specify)			M	lonth	Day Year
	ڄ	9 Unknown						<u> </u>		
	۵	Part II. Other significant conditions co	optributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.		_		e cause of death?
	ted	arem	1.1	7		\	1 Yes	2 🗆 No	3 Prob	ably 4 Minknown
	npie	Chron	wythdo si	the bone	worning &	whole	24a. Was an autopsy		prior to cor	psy findings available npletion of cause of
	ဒီ			<u> </u>)		performed		death? 1 ☐ Yes	2) No
	Be	25. Was case referred to medical examiner?	Hospital:		. all DOA Othe	26. Place of Death				
	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injur (Month, Day		I 3 DOA	4 Nursing nor	me 5 Residence			"
	ij	1. Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury	Work	(? Yes 2 □ No		.,.,		
	Ca	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, str	eet, factory, office		28f. Location (Stree	t and Num	ber or Rura	l Route Number,
	Ser						City or Town, S			
	Medical Certification:	29a. Certifier 1 ✓ Certifying Phyone) 1 ✓ Certifying Phyone	ysician: To the best o iner: On the basis of and manner stat	f my knowledge, death examination and/or in ed.	occurred at the time vestigation, in my op-	e, date and place, a pinion, death occurre	and due to the caused at the time, date	e(s) and m and place	nanner as st , and due to	ated. the cause(s)
	Σ	29b. Signature and title of certifier	- 0 00	1	29c. License	4 .	29d.	Date sign	ed (Month, I	Dey, Year)
		12 13.	his	- hwp	.50	362		Une	21	12006
		30. Name and address of person who do	completed cause of de	ath (Item 23a) (Type, Seton	DRIVE	Cumk	perland	-1.N	10 2	2/502
Stat		31. Date filed (Month, Day, Year)		r's Signature	- 00					
istra		JUN 2 3 201	06 Maria	, St Ap	BULL!					
1/20	01		₹							

Registrar

Physician /Medica Examine

Funeral Director

5	State of Maryland / Department of Health and Mental Hygiene	2	0	0	1

			1 - For State Registrar	State of	Maryland		artment of <i>tificate of</i>		ınd Me		iene 20	06	1995
	Physici /Medi		1. Decedent's Name (First, Middle, L Irving Kurt		isher					Date of Deat June 7		Year	3. Time of Death 9:30 A M
	Examir		4a. Facility Name (If not institution, g 1801 East Jeffer				4b. City, Town, Rockvil		f Death		4c. County of Montgo		
	Funeral Director		5. Social Security Number 6. 120-28-5264	Sex 7 1⊠M 2□F	'. Age (In yrs. Ia 93	st birthday) Yrs.	If Under 1 Yea Months Days			Date of Birth 0/93/7 19/1	L'aar) P	9. Birthplace Country O Land	ce (State or Foreign
	rland low		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d	. Inside City Limits
	Ba-f eh	Director		tgomery			Rocl	cville					1-√Yes 2□No
	h with th	ai Dire	10e. Street and Number 1801 East Jeffers	on Street	#522		10f. Zip Code	20852		10	og. Citizen of Wh	S · A ·	?
036	be filed within 72 hours after death with the Maryland ital Hygiene. dother then "natural", or items 23a or 28a-1 show event, it a Medical Examinar maint be motified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	No	1	Vas Decedent of f Yes, specify Cu ☐ Yes 2☑ No	ban, Mexican,	in? (Specif , Puerto Ric	fy Yes or No- can, etc.)		American White, etc	
51215-0036	ithin 72 ho ie. ien "natur Medical	Completed	15. Decedent's t (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4	4or 5+)	(Give	lent's Usual Occu kind of work done OO NOT use retire	during most	of working	1	6b. Kind of Busi	ness/indus	itry
	Hygi Hygi Ther	e Cor	12 17. Father's Name (First, Middle, Las	it)			OWNI	T	's Name (F	First Middle M	FOOD PA		G COMPANY
ylan	should be nd Mental marked c	To Be	Me	yer Mishe	er				, , ,		"unknov		
Maryland	d 2 sho th and t7 ie mu traum		19a. Informant's Name/Relationship Gayle Rothsc		ighter						City or Town, St.		20854
ore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: if item 27 ie marked any injury or other traumatic en <u>pnce</u> .		20a. Method of Disposition 12 Burial 2 Cremation 3		20b. Pla	ce of Dispos	sition (Name of patory or other pla		Date		Oc. Location - Ci		
Baltimore,	permit. Pages Department of Importent: If it any injury or o		4 Donation 5 Other (Spec	ify)	Mont		e Cemete			2006	St.	Albar	ns, NY
n D	Depa Impo		(a submo	11300		Dấ 11	nžansky- 70 Rocky	Goldbe ille P	rg Me	emorial Rockvi	Chapels 11e, Mar	, Inc	c. 1 20852
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cau y one cause on ear	used the death. ch line.	Do not ente	er the mode of dy	ing, such as ca	ardiac or re	espiratory arre	st,	Ap	pproximate terval Between nset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. <u>Ischem</u> Due to (or	nic Card		pathy						3 Years
	Examiner	<u>_</u>	Sequentially list conditions,	b	ras a consecus	nna -0							
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to minimum action cause. Enter Underlying Cause (Disease or injury that initiated events	c.	as a conseque	nica orj.						1	
8/60,	cate be executed physicien and the burial-transit	cal Ex	resulting in death) Last	Due to (or	ras a conseque	ince of):							
0	nificate ng phys as the	l च	IF FELLILE	d			_		37/	- 17			
.c. Box	uires that the death certific signed by the attending p d be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 □ Fetal d nt at time of dea	leath 3 🗌	Ectopic pregnand Other (specify)	У			23d. Date of Month		y Year
ecoras, r	requires that een signed b nould be deta	þ	Part II. Other significant conditions Hypertension	contributing to dea	th but not result	ing in the un	derlying cause gi	ven in Part I.			tcco use contribu		ause of death?
Hec	The taw te has b age 2 st	Completed	Chronic Renal Inst	ıfficienc	У				_	24a. Was an autopsy performe	ed? prio	r to comple th?	findings available etion of cause of
	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Hospital:		-	100		72. 1	heck only one		Yes 2	J NO
_	g Phy er this eral d	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		NOutpatient 8b. Time of Injury	28c. Inju		28d		ce 6 Other (Specify)	
DIVISION	al or Atten after dea i Director d in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of	Injury - At hom , etc. (Specify)	e, farm, stre	et, factory, office			Location (Stre City or Town,	et and Number o State)	or Rural Ro	oute Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier (Check only one) Certifying P Certifying P Certifying P Certifying P	hysician: To the be miner: On the basi and manner	is of examination	edge, death n and/or inve	occurred at the trestigation, in my o	me, date and ppinion, death	place, and occurred a	due to the cau at the time, date	se(s) and manne e and place, and	or as stated due to the	t. cause(s)
	To With	Σ	29b. Signature and title of certifier	12061	am		29c. Licens D0057			290	d. Date signed (A		
-	ASK.		30. Name and address of person who	7		3a) (Type. P					JUNE	/, 20	U6
5			Damien J. Doyle,	MD 1801	East J	effers	on Stre	et, Roc	ckvil	le, Mar	yland 2	20852	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 9 2	006	istrar's Signatur	Apa .	de						

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 8, 2006 6:00 A M Charlotte C. Murphy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary s 9. Birthplace (State or Foreign 40301 Waterview Drive Mechanicsville
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1954 Georgia 1 □ M 2 🕅 F Months Hours 51 Ϊ9. Novembér Director 214-72-3027 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show in then "natural", or items 23a or 28a-f show the Medical Examiner must be restilled at 1 Yes 2 No Maryland Director St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40313 Waterview Drive 20659 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Foster Care Provider Day Care permit. Pages 1 end 2 should be filed v
Department of Health and Mental Hygie
Important: if item 27 is marked other ti
eny injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cecil Allen Mary E. Bozeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kenneth W. Murphy/husband 40301 Waterview Drive, Mechanicsville, MD 20659 June 11, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem. Charlotte Hall, MD 2006 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., bust 30195 Three Notch Rd., Charlotte Hall. MD 20622 Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Fansi Hona /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate hes been signed by the attending physicien and pege 2 should be detached for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes ☐ No
9 ☐ Unknown Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending within 24 hours efter death.

To the Funerel Director: All completely filled in by the fu 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated. To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 06 son who completed cause of death (It m 23a) (Type, Print) (David Gallatin 31. Date filed (Month, Day, Year) State JUN Registrar

			1 - For State Registrar	State of M	laryland .	Depa	artmen rtificat	t of H	lealth a Death	and M	lental H	ygien Reg. N		06	199	955
٠	nb.		1. Decedent's Name (First, Middle, I	Last)							2. Date of D		ay	Year	3. Time of	Death
	Physici /Media		Edmund	Nash							June 4		006	1001	8:00	P •M
	Examir	er	4a. Facility Name (If not institution, g	rive street and number,)		4b. City,	Town, or	Location of	of Death		4	c. County	of Death		
			Manor Care Che						Chase				Montg			
ij,	Funeral			. Sex 7. A	ge (In yrs. last	Yrs.	Months	Days	If Under Hours	Min.	8. Date of B	av. Year	1000	Cour		r Foreign
· V	Director		399-05-1235 Usual Residence of Decedent		96	113.					Dec.	24,	1909	Can	ada	
	/land		10a. State 10b. County		10c. City, T	own or Lo	cation							1	0d. Inside Ci	ty Limits
	Man Ind	ţ	D.C. None		Wast	ningt	on								†x☐ Yes	2 🗆 No
	r 28g	Director	10e. Street and Number		Hasi		10f. Zip	Code				10g. C	itizen of W	hat Cour	ntry?	
	th wit		3140 Wisconsin	Ave. N.W.				2	20016				U.S	Δ		
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces		13. \	Nas Deced			gin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race	- Americ	an Indian,	
စ္တ	or It	F	1 Never Married 2 Married	1 ☐ Yes 2.K. If Yes, Give			ı □ Yes	_	Specify:		riloari, otc.,			k, White, : Whi		
Ö	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-1 show he Wadigal Examinar must be notified at	d by	3 ☐ Widowed 4 ♣ Divorced	Year or Dates:									эрөспу.	. 4411.1	LE	
꾸	"nat	Completed	15. Decedent's (Specify only highest of		1	6a. Deced		rk done a	during most	t of worki	ng	16b.	Kind of Bu	siness/Ind	dustry	
12	within ene.	щ	Elementary/Secondary (0-12)	College (1-4or 5+	5+)		onomi)			TT .	c c-			
Q 7	be filed value Hygie		17. Father's Name (First, Middle, La.			EC	OHOM	LSL	18. Mothe	er's Name	(First, Middle	-	S. Go		ment	
an	ld be ental ked c	To Be	Boleslaw Nasiero	orraled												
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural; or Iteme 23s or 28a-f show aumatic event, the Wadisal Expriner must be notified at	_	19a. Informant's Name/Relationship		1	19b. Mailin	g Address	(Street a	Max and Numbe	ya M er or Rura	agdale	ha K	or Town,	OWSKa State, Zip	Code)	
	and 2 ealth a n 27 is		Edward T. Love/P	ersonal Rei	. 4	816 1	Moor1	and	Lane.	Bet	hesda,	Md.	208	14		•
e,	- T 5 5		20a. Method of Disposition		20b. Place	of Dispo	sition (Nan	ne of	-	D	ate		ocation -		wn, State	
Ĕ	Pages nent of I		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Met: Cre	ropol mator	itan		J	June 200	8, 06	A1e	xandı	ria.	Virgin	าเล
altimore,	permit. Departn Importe any Inju		21. Signature of Funeral Service Lie	nsee	, 525.			nd Addres	s of Facilit		Vol Fu				122821	114
<u>m</u>	89 E 29		Henry w	. Turk							N.W.				C. 200	07
丸			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause by one cause on each I	d the death. D	o not ente	er the mod	e of dying	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Bety	
	Physician		Immediate Cause (Final disease or condition	a Cardia	c Arrhs	zthmi	а								Onset and D	
*	/Medical Examiner		resulting in death)		a consequen		ц									
	Lamine	_	Sequentially list conditions,	b												
	ed sit	Examiner	finny leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as	a consection	nalor):										
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8760	death certificate be executed e attending physician and ad for use as the burial-transit															
687	ficate phys s the	edicai		d											1052	
ŏ	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy								23d. Date	of delive	rv	
\mathbf{m}	death e atte d for	cia	in the past 12 months?	1☐Live birth 4☐Pregnant a			Ectopic pro Other (sp.	egnancy ecify)					Mon			ear
О	y th	hys	9 Unknown	9 Unknown												
	The law requires that ate has been signed b bage 2 should be deta	by P	Part II. Other significant conditions		out not resulting	g in the un	derlying ca	ause give	n in Part I.		23e. Did	tobacco	use contri	bute to th	e cause of de	ath?
ğ	w require been sign	ed	Atrial Fibrill	ation							1 🗆	Yes 2	□ No :	3 🗌 Proba	ably 4 🛣 U	nknown
Records,	as be	Completed									24a. Was		24b. W	ere autop	sy findings a	vailable
		TO TO										ormed?	de	eath?	npletion of ca 2 □ No	use or
Vital	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only					
	Physicien: r this certific ral director,	2	1 ☐ Yes 2 🖾 No		ent 2 ER/				+ ⊠ IA⊓I	rsing Hom	ne 5 🗆 Res	idence	6 □Othe	(Specify)	
Ĕ	ding F	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b	o. Time of Injury		8c. Injury Work			8d. Describe	how inju	ry occurre	d		
Sic	or:	icat	2 Accident investigate 3 Suicide 6 Could not	he -	una Athana	(M		es 2□N		06 1	(0)				
Division of	P Tree	Certification:	4 Homicide determine	d 28e. Place of Inj building, et	c. (Specify)	tarm, stre	et, factory	, office		-	8f. Location (City or To	wn, State	nd Numbe. e)	r or Hural	Route Numb	er,
	ppita ours ieral		29a. Certifier 1 ☑ Certifying F	Physicien: To the best	of my knowled	dge, death	occurred a	at the time	e date and	d place, a	nd due to the	Causo/s) and man	nor as at	atod	
	e Hos	edicai	(Check only 2 Medical Execute)	eminer: On the basis of and manner st.	f examination	and/or inv	estigation,	in my op	inion, deat	h occurre	d at the time,	date and	d place, ar	nd due to	the cause(s)	
	To the Ho within 24 t To the Fu completaly	M	29b. Signature and title of certifier	and .			29c	. License	number			29d. Da	te signed	(Month, E	Day, Year)	
	12						D	0054	566			Tuna	e 5,	2006		
	10		30. Name and address of person who	completed cause of c	leath (Item 23a	a) (Type, F	-	J T	<u> </u>			June	٠ ا	2000		
			Sunitha Bhogavi	11i, M.D.	1220 A	A Eas	t Jor	ора Б	Rd. #2	230 7	Cimoni	ım, l	Md. 2	1286		
- 1	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	do	wer									
1	Registr	ar	JUN 9	2006	and the	1										

			1- State of Maryland / Dep negistrar Amend #7&8 Per FH G858 8/24/88	eartment of Health and I	Mental Hygie	ne2006 9956
	Physic /Medi		Decedent's Name (First, Middle, Last) JOHNNY PUGH		2. Date of Death	3. Time of Death 17:07p M
	Examir		4a. Facility Name (If not institution, give street and number) Fort Washington Hospital	4b. City, Town, or Location of Death Fort Washington	1	4c. County of Death Prince Georges
	Funeral Director		5. Social Security Number 577-34-4019 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 79 83 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 1 (Month, Day, Ye 09-06-15	926 9. Birthplace (State or Foreign Country) Cleveland, Chio
	Maryland a-f ehow	tor	10a. State 10b. County 10c. City, Town or L Prince Georges Fort Was			10d. Inside City Limits 12 Yes 2 No
	a or 284	I Direc	10e. Street and Number 12803 Prestwick Drive	10f. Zip Code 20744	10g.	Citizen of What Country?
9036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other then "natural", or Iteme 23s or 28s-1 show event, I'm Medical Exercities must be trydified at	tby Funeral Director		Was Decedent of Hispanic Origin? (Sji Yes, specify Cuban, Mexican, Puerti	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:Black
21215-0036	within 72 h ene. then "natu he Medical	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Naval Operations	king 16b.	Kind of Business/Industry Government
Maryland 2	be filed stal Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last) unknown	<u> </u>	e (First, Middle, Maid	
	D = 2 = 1		19a. Informant's Name/Relationship (Type, Print) Andrea Malcolm Assisted Living Manager 128	ing Address (Street and Number or Ru. 03 Prestwick Driv	ral Route Number, City e, Fort Wa	y or Town, State, Zip Code) shington, MD 20744
Baltimore,	00		4 Donation 5 Other (Specify)	maton, or other place)		Location - City or Town, State shington, DC
Ball	permit. Pag Department Important: f any injury o		· mm			ashington,DC 20011
ı	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
8760,	ate be executed XX hysician and With burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C	potension tricular for	ly Cena	ha bottomesi
Box 6	that the death certific hed by the attending p detached for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	6 6	b	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
	as LL	Completed	Signoid Codor Conces		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1	0.4	Check only one	
ō	g Phy er this eral d	2	27. Manner of Death 28a. Date of Injury 28b. Time of	IL 3LI DOX 4LI Nursing He	me 5 Residence	
ion	Attending r death. ctor: After by the funer	atlo	1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,
É	p aging a	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital within 24 hours a To the Funeral (completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause(ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	Tor	≥	29b. Signature and title of centrier	29c. License number		ate signed (Month, Day, Year) Ne, 7, 06
R	(3)		30. Name and address of ders who completed cause of death (Item 23a) (Type,	Print) Print) PRINT MO	20902	
9"	Sta Registr	re l	31. Date filed (Month), Day, Year) 1104 0 9 2006	W		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physici<u>an</u> WAYNE L. PRICE June 2006 3:40 Рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Prince Georges Hospital Center Cheverely If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Vinginia 8. Date of Birth (Month, Day, Year Aug. 6, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F 1966 230-21-5108 39 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itema 23a or 28a-f show amy njury or other treumatic event, the Madical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No MD Prince Georges Hvattsville Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2610 Kirkwood Place #104 20782 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ∑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black à If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Short Order Cook 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Larry M. Price Mary A. Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Price/Mother 101 Graham Rd.-Richmond, VA 23222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 6/7/06 'Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility reene Funeral Lome, INC. 21. Signature of Funeral Service Licenses nelson & Shune 814 Franklin Street - Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner S _uential y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the 88 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performed 2 M No 1 Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 V No 1 VInpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 V Natural 5 Pending death. 1 Yes investigation Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funerel Direc filled in by 4 Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY MD 20185 3001 HOSP TAL MESKEREM 31. Date filed (Month, Day, Year) State JUN 0 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] § For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1, 2006 5:05 a M June Graciela H. Perez /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Bethesda Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10–15–1920 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖔 F Months Days 572-90-5163 85 El Salvador Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examinar must be notified at Y Yes 2 No P.G. Maryland Hyattsville Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 2215 University Boulevard 20783 U.S.A. Ітетне 23а by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural; or Item any injury or other traumatic event, it a Mudical Examples 1 Never Married 2 Married ı‱ Yes 2□No *Specify:* Salvadoran White If Yes, Give Year or Dates: Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Restaurant Elementary/Secondary (0-12) College (1-4or 5+) Chef 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesus Hernandez Sara Mena 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8106 Loving Forest Court Springfield, Virginia, 22153 19a. Informant's Name/Relationship (Type, Print) Sara Perez-Garcia/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Comfort Cemetery 6-8-06 * 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th Street, N.W. Washington, D.C. 20010 C. Dacon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MPHOMA Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2X No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signi page 2 should be 1 ☐ Yes 2 🖔 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 (20No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific H 602128

8; C

or Attending Physicien: The law requires that the death certificate be executed

Box 68760

P.0.

Division of Vital Records,

death

Baltimore, Maryland 21215-0036

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 0 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pruong Bao, M.D.

9715 Medical Center Dr.

(0 - B - 2000)

20850

Rockville, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Alice A. Parran 12:00 P M Jun 5, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick 10 Central Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 Maryland 5. Sociaf Security Number 7. Age (In yrs. last birthday) Days Hours 1 M X F Feb 4, 1923 217-28-8553 83 Yrs Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Prince Frederick Director MD Calvert 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20678 U.S.A. 10 Central Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black þ **X** Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)

Funeral

Director

event, the Medical Examiner must be notified at

Iteme 23a or

0

natural

other then

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 le marked ofth any long you on other traumatic event, pine.

Physician /Medical

Examiner

be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death, To the Funerel Director: After this certificate has been signed by the ettending physicien and

cate has been sig , page 2 should b

à

filled in

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

Baltimore, 1

P.O. Box 68760.

Division of Vital Records.

death

College (1-4or 5+)

William Jones

18. Mother's Name (First, Middle, Maiden Surname) Lena V. Morsell

19a. Informant's Name/Relationship (Type, Print) Hamilton Parran, Jr./son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 776 Prince Frederick, MD 20678

20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Plum Point UM Church Cemetery

Cook

20c. Location - City or Town, State Huntingtown, MD

Restaurant

21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus

22. Name and Address of Facility
Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678

Date

06/10/06

Immediate Cause (Final disease or condition resulting in death)

Sequentially fist conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ne c	ause on each fine.	
a.]	lent Eccelar	Librilladeon
	Due to (or as a consequence of):	
b		
	Due to (or as a consequence of).	

Approximate nterval Retween Onset and Death

Sudden

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

23c. ff yes, outcome of pregnancy 2 Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

3 DOA

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 1 No 1 ☐ Yes 24a. Was an

3 Probably 4 Unknown

25. Was case referred to medical examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home

3 2 No 1 Yes 26. Place of Death (Check only one) 5 Pesidence 6 □ Other (Specify)

28d. Describe how injury occurred

autopsy performed

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

1 Yes 2 No 27. Manger of Death 1 Natural

29b. Signature and title of certifier

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

28c. Injury at Work? 1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

2 Accident

3 Suicide

4 - Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

6/6/06

sunates

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Kioumarce Yazdani, M.D. Huntingtown, MD 20639

State Registrar

31. Date filed (Month, Day Year) 32. Registras Signature 2000

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 Rosenberg June 6, 2:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Nursing Home Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Director 87 Yrs 215-44-8397 25, Dec. 1918 Maryland Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10b. County or 28a-f show 10d. Inside City Limits re!; or iteme 23a or 28a-f shor Examiner must be notified at Director Maryland Montgomery Rockville X□Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Adclare Road U. S. A. 20850 deeth v Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: δ 3 Widowed 4 Divorced "nature!", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other th eny injury or other traumatic event, tra porce. Executive Assistant 12 Years 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Sadie Roberts Albert Rosenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11575 Greenwich Point Road, Reston, Jack J. Rosenberg - Nephew Injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hebrew Friendship 6/9/2006 4 □Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service License Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, Maryland 20852 onald (23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a cur sequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.
To the Funeral Director: Atter this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the bursti-transit Due to (or as a consequence of). Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has l page 2 s 24a. Was an autopsy performed? Division of Vital 1 Yes 2 No 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 7, 2006 D51916 tatticia 30. Name and address of person who completed cause of death (Imm 23a) (Type, Print) Patricia Tomsko Nay 11119 Rockville Pike, G-100, Rockville, Maryland 31. Date filed (Month, Day, Year) istrar's Signature 32 State JUN 9 2006 Registrar

			For State Registrar	State of M	-	-	rtment of H		d Mental Hy	giene Reg. No.	006	19961
		*	Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death
	Physici /Medic		VIRGINIA	W.		RO	SSY		Month	Day 7	O6	9:50 AM
	Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town, or	Location of E	Death		nty of Deat	
	9,	*	ATLANTIC GENE			theford	BERL If Under 1 Year		Hrs R Date of Di		RCEST	
	Funeral Director		5. Social Security Number 214-07-9761	1 □ M 2 🔀 F	Age (In yrs. last birt 85		Months Days		Min. 8. Date of Bir (Month, Da	ay, Year)	9. Birti	hplace (State or Foreign untry) [ARYLAND
l			Usual Residence of Decedent						001. 1,	1920	171	ARILAND
	arylan show	_	10a. State 10b. County		10c. City, Town							10d. Inside City Limits
	with the Mary e or 28a-f sh be nuillied	Director	DELAWARE SUSS	EX	SELBY	XVIL						1 ☐ Yes 2 📉 No
	th with t 23e or 2		10e. Street and Number	DDTVE			10f. Zip Code 199	75		10g. Citizen		untry?
	ter death Items 23	Funerai	37054 MALLARD	12. Was Deceder	nt Ever in U.S.	13. W			? (Specify Yes or No uerto Rican, etc.)	US - 14. F	ace - Amei	rican Indian,
٥	USO urs after death v ai', or items 236		1 Never Married 2 Marrie	Armed Forces 1 ☐ Yes 2 ff Yes, Give			Yes, specify Cuba. □ Yes 2. X No	n, Mexican, P Specify:	uerto Rican, etc.)	1	lack, White	
S	72 hours "natural",	d by	3 X Widowed 4 □ Divorced	Year or Dates						Spe	. 111	HITE
L	n 72 i	olete	15. Decedent's (Specify only highest	grade completed)		(Give ki	nt's Usual Occupa ind of work done o O NOT use retired	during most of	working	16b. Kind of	Business/l	ndustry
2	C Z IZ IS-UU30 filed within 72 hours after death with the Maryland Hyglene. wher then "natural", or items 23s or 28s-f show ant, it s Madical Extending and	Completed	Elementary/Secondary (0-12)	Colfege (1-40	r 5+)	REA	LTOR			REA	L EST	'ATE
	Ind ZIZI3-0-0 be filed within 72 ho tal Hygiene. d other than "natu event, It a Modical	Bec	17. Father's Name (First, Middle, La						Name (First, Middle		ame)	
<u>.</u>		²	EMORY	WRIGHT				SADI		COOPER		
	Mar d 2 sh d 2 sh th and 7 is n traum		19a. Informant's Name/Relationship STACY ALLEN/GRA			-			r Rural Route Numb SOUTH RID			, ,
	re, Maryla s 1 and 2 should f Health and Mer tiem 27 is marke other traumatic		20a. Method of Disposition	NDDAUGHIEK	20b. Place of	Disposit	tion (Name of		Date RID	20c. Locatio		
	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				RANS CEM		/12/06	MILLSI	BORO.	DELAWARE
3	Baltimore, n permit. Pages 1 and Department of Health Important: if item 27 any injury or other t		21. Signatu hy neral service Li			4	Name and Addres				,	
	n 82559	117	Muller W	Aust					HOME, SE		LE, DI	E. 19975
			23a. Pan1. Enter the disease, or constant shock, or heart failure. List or	omplications that caus nly one cause of each	ed the death. Do n line.	not enter	the mode of dying	g, such as car	diac or respiratory a	rrest,	:	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a ENCE	ph2/1	カ	2					10 dzys
	Examiner			Due to (or a	a consequence o	of):						2
0	ž 7	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	is a consequence o	of):					_	
0660	cate be executed physician and sthe burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
	HECONDS, P.O. BOX 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit.		resulting in death) Last	Due to (or a	is a consequence of	of):						
2	cate be e	hysician/Medical		d								
-	BOX 62	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ie of pregnancy					224	Date of defin	von.
19	death death death death	iciar	in the past 12 months?	4□Pregnant	2 Fetaf death at time of death		ctopic pregnancy Other (specify)				Month	Day Year
	that the de detached detached	hys	9 Unknown	9□ Unknown								
	S, F res tha igned be dei	by P	Part II. Other significant condition	s contributing to death	but not resulting in	the und	lerlying cause give	en in Part I.			-	the cause of death?
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		e Co	25. Was case referred to medical					00 51	1 ☐ Yes	2 € No	1 🗆 Yes	2 No
	OT VITA Physician: this certific	0	examiner?	Hospital: 1 Inpa	tient 2 ER/Out	tpatient	3□ DOA Othe		Death (Check only only only only only only only only		ther (Saec	ntv)
	O ₹ ₹ ½	T:UC	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of fn (Month, D		ime of	28c. Injury Work	at	28d. Describe I			
4inia - 976	SIO tendi leath. tor: A	catic	2 Accident investiga 3 Suicide 6 Could no	t he			M 1 🗆 Y	Yes 2 □ No				
Vir	DIVISION Hospital or Attending 4 hours after death. Funeral Director: Afte	Certification:	4 Homicide determin	ad 28e. Place of I	njury - At home, fai etc. <i>(Specify)</i>	rm, stree	et, factory, office		28f. Location (S City or To	Street and Nui wn, State)	mber or Rui	ral Route Number,
21	Spital lours a		29a. Certifier 1 Certifying	Physician: To the bes	st of my knowledge	, death o	occurred at the tim	e, date and p	lace, and due to the	cause(s) and	manner as	stated
2/4	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely fi	edical	(Check only 2 Medical Ex	kaminer: On the basis and manner:	of examination and	d/or inve	estigation, in my or	oinion, death o	occurred at the time,	date and place	e, and due	to the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	LUIC	\ \\	1	29c. License			29d. Date sign	ned (Month	, Day, Year)
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	70m	H		ho completed cause of	death (ftem 23a) (Type, Pi	rint)	1-	Berlis,	mo	3)	1811
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 9	1.40	strar's Signature		wet!					,

			1 - State Registrar AMEND#8perINF, 6	State of Marylan /14/06,BW,McCo	d / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of Health te of Deat	and M		ene200	6	9962
			Decedent's Name (First, Middle, Last)						2. Date of Death Month		3. Tir	ne of Death
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ш			Holy Cross Ho		to a think do	If Lind	Silver S	prin	g a Data of Birdle	Mont	gomer	y tata as Fasaina
	Funeral Director			7. Age (In yrs.	Yrs.	Month:	er 1 Year If Und s Days Hours	s Min.	(Month, Day,	7 1 9 R 2	Country)	vland
			214-30-0193 Usual Residence of Decedent	7.4		1			TOTAL A	23,1992	HUL	y Tana
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Insi	de City Limits
	Mar	tor	Md Montgom	ery	K	ensi	ington					Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Z	ip Code		10	g. Citizen of Wha	it Country?	
	23a	ral	3906 Hampden				20895			U.S.		
	er de	Funeral		Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Dec	edent of Hispanic (ecify Cuban, Mexic	Origin? (Spe can, Puerto F	cify Yes or No- Rican, etc.)		American India White, etc.	an,
9	s afte	by F	1 ☐ Never Married 2 ☐ Married 33 Widowed 4 ☐ Divorced	1 ☐ Yes		1 □ Yes	XXNo Speci	ity:		Specify:	D11-	
3	tural		15. Decedent's Educa	ation	16a. Dece	dent's Us	ual Occupation		1	6b, Kind of Busin	Black ess/Industry	
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2	othe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mo	ther's Name	(First, Middle, M	laiden Sumame)		
9	Menta Menta arked	10	James Dig	gs				Genev		cher		
0	2 sho and I is ma	10	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Addre	ss (Street and Nun	nber or Rura	Route Number,	City or Town, Sta	te, Zip Code)	28216
≥ (e	end eelth m 27 her tr		Reginald Lee	(Son)			Secretar					
0	Pages 1 nent of He nent if iten	,	20a. Method of Disposition 1 ☐ Burial 2€€€remation 3 ☐ Re	moval from State	Place of Dispo emetery, crei	matory`o	other place)	_		0c. Location - Cit		
Saltimor	thent:		4 □ Donation 5 □ Other (Specify)	-) / /	tro C			6/9	/06 I	Alexand	ria,	Va
g D	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mentalla Hygiene. Department if them 27 is marked other then "natural" or iteme 23a or 28a-f show important: if them 27 is marked other then "natural" or iteme 23a or 28a-f show eny injury or other traumatic event, it a Medical Examinar mast be notified at QDGs.	_	21. Signature of Funeral Service Licenses	/ V L	100		and Address of Fac NWO en Fi	•	1 Home	P A 2	0850	
	20204		22a Part 1 Enter the disease or complic	ation that caused the deat	h Do not ent	246	wden Fu	shing	ton St,	Rockv	ille,	_Md ximate
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one		11. DO 1101 9111	(01 (110 111	ode of dying, such	as cardiac of	1 103piratory arro	51,	Interva	al Between and Death
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	e dee the al	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	leath 5	Other (specify)			Wichti	Cay	1041
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ō	iding Physician: th. ; After this certifice funeral director, i	⊢	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at Work?		8d. Describe how	nce 6 Other (<i>Specity)</i>	
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	al or Attending F efter death. I Director; After d in by the funeri	Hice	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	reet, facto	ory, office	2	8f. Location (Stre City or Town,	eet and Number of	or Rural Route	Number,
5	s effe ai Dir	Certification:	4 Difformede	Building, etc. (Special	y/				Only or Younn,	State)		
	To the Hospital or At within 24 hours effer of To the Funeral Directompletely filled in by	cai	29a. Certifier Check only 2 Medical Examin	ician: To the best of my known: or: On the basis of examina	wledge, deat	th occurre	d at the time, date	and place, a	ind due to the car	use(s) and manne	or as stated.	use(e)
	the H nin 24 the F uplete	ledicai	one)	and manner stated.								1 -7
	To To To To	Σ	29b. Signaturé and title of certifier			2	9c. License numbe	er .	29	d. Date signed (N	ionth, Day, Ye	ear)
	5		MINITA				D3233	32		June	7, 200	06
			30. Name and address of person who con				7 C	220	C = 1	Const	~ 1/100	2002
			Suresh K. Gupta 31. Date filed (Month, Day, Year)				Ave Sut	_ 220	STIVE	sprin	9,MD20	J J U Z
	Sta Registi		JUN 9 200	16 Parque A	ture	ante	7					

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#24 apenMD6/9/06, EMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0605 KENNETH JUNE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL CONTER BALTIMORE PANDALISTOWN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Nov. 18, 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 277-30-5335 72 Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show the Medical Examiner must be notified at Delaware Sussex Laurel 1 Yes 2 No Funeral Director 10e. Street and Number 135 Lakeside Drive 10f. Zip Code 10g. Citizen of What Country? United States 19956 death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1948–1976 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) United States other then College (1-4or 5+) Military Officer permit. Pages 1 and 2 should be flied w Department of Health and Mental Hygier Important: If Item 27 is marked other it ery Injuryo other traumatic event, that once. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter H. Slarb Letha Wandel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
135 Lakeside Drive Laurel, Delaware 19956 19a. Informant's Name/Relationship (Type, Print) Judy Slarb -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Arlington National Cemetery 6/26/2006 Arlington, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald Vole Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EMBOLISM 1 HOUR /Medical **Examiner** ECTAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Anpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury s efter dea. rsl Director: After 1 Matural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funers! C Printifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) ÷ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062808 men 2006 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 CROSSROADS RD SWITE 312 OW/NGS MILLS, MID 21117 SOMERNILLE 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 9 Registrar

06-04177		Please T							
James Noel Shew		State of Maryland	•			Mental F	łygiene	20	00 1000
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Medical Examine		N. Shew					June 16, 2	2006	1703 hrs
(institution, give street and number)		city, Town, or t rederick	ocation of Deat	h	4c. County of De Frederick	eath
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Baltimore, permit Pages I ar Department of Hee Important: If ite	1 Burial 2 X C		late	erick C		r 6/	10/2006	Frederical	k, Maryland
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built in the funeral director.	IF FEMALE: 23b. Was decedent preg past 12 months? 1 Yes 2 No 9 Part II. Other significar	23c. If yes, outcoment in the	ome of pregnand	cy 2 Fetal d	eath 3	Ectopic pregr	nancv	23d Date of deli Month	very Day Year
ox 687 eath certific	past 12 months?	4 Pregnant a	at time of death		(Specify)		,		,
Box e death c the atten ed for us	7 Yes 2 No 9	Unknown 9 Unknown							
on the set of by the etache		nt conditions contributing to dea	th but not result	ting in the unde	rlying cause gi	iven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
ires that the signed by I be detached	AG p						1 Ye	s 2 No 3	Probably 4 V Unknown
of Vital Records, ing Physician: The law require After this certificate has been signed.	Completed						24a. Was		autopsy findings available to completion of cause of
co e law e has	<u> </u>				_		perfo	ormed? death	1?
tal Rec	25. Was case referred to	n modical			26 Place	of Death (Check	1 Yes	2 No 1 🗸	Yes 2 No
ician:	examiner?	Hospital:	ient 2 ER	/Outpatient 3		Other:	ing Home 5	Residence 6 0	thor:
of Vil	27 Manner of Death	No 28a. Date of In		b. Time of Injury		y at Work?		how injury occurred	
n of oding Ph.	1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	(Month, Day	Year)		1 T	es 2 No	1.	, , , , , , , , , , , , , , , , , , , ,	
Division al or Attendia rs after death. al Director: A	2 Accident	Investigation TIU 0/12	Z/ZUUO F1 Injury - At home	nd 5:34 p		uilding etc	unknown 28f Location (Street and Number or	Rural Route Number, City
Divis pital or At purs after d cral Direct filled in by	3 Suicide 6	Could not be	House	, raini, en est, re			Brunswi	State 11 COnco	rd Drive
Divisior Hospital or Attend 24 hours after death Funeral Director: teely filled in by the 1		tifying Physician: To the best of		dooth occurred	at the time de	to and place, or	1		startad
To the Howithin 24 h To the Fu	(Check only	dical Examiner: On the basis of ex							
To the within To the comple	29b. Signature and title	and manner stated of certifier	d		29c. License	e number		29d. Date signed	Month, Day Year)
	Olio	D `			O.C.N			June 17, 2006	
	unk	-	d 00						
	30 Name and address Ana Rubio MD.	of person who completed cause of Assistant Medical Exa		a) 1 Penn Stre	et. Baltimo	re. MD 2120	01		
			rar's Signature		-,	.,			
Sta Registr	. 1 4 1	N 2006 2006	be D	Anna					
Moglott									

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			For State Registrar	State of M	arylan		artment of H		ind Mental Hy	giene	6 19965
	传	e .	Decedent's Name (First, Midd	le, Last)					2. Date of De	ath	3. Time of Death
	Physicia /Medic	_	Vada Jole	ene Schoon					June	•	006 1:30 P M
	Examin		4a. Facility Name (If not institutio)		4b. City, Town, or	Location o		4c. County of	
	397 4			Memorial	Hosp	ital	Freder				derick
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs.	last birthday) Yrs.	Months Days	If Under 2 Hours	Min. (Month, Da		Birthplace (State or Foreign Country)
100	Director		614-45-7825 Usual Residence of Decedent	. X		Yrs.			January	30, 2003	Japan
	land ow		10a. State 10b. County	,	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Man fied	ţo	Maryland Frede	erick	F	'rederi	ck				1 XYes 2 □ No
	h the	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
	72 hours after deeth with the Maryland natural, or Itame 23a or 28a-f ehow Alcal Examinat must be notified at	Funeral Director	7205 West Hut	ff Boulevard			21702			U.S.A.	
	r dee	ner	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig	in? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Black.	American Indian, White, etc.
36	s afte	by Fu	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	No		1 ☐ Yes Ž No	Specify:		Specify:	white
0	hour tural	q pe		Year or Dates:		16a Dece	dent's Usual Occupa	ation		16b. Kind of Busin	ages/Inductor
5	in 72 in 72	Completed	(Specify only highe	est grade completed)		(Give	kind of work done of DO NOT use retired	lurina most	of working	TOD. KING OF BUSIF	1 0 55/11/dus(1)
212	yiene.	E	Elementary/Secondary (0-12)	College (1-4or	5+)		none			none	
פַ	e filed Il Hygir other	BeC	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name (First, Middle,	Maiden Sumame)	
<u>la</u> r	Aental Aental rked c	To E	Jack Schoon					Je	ssica Feim	er	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important; if item 27 ie marked other than "natural; or itame 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at ance.		19a. Informant's Name/Relation: Jack Schoon —						r or Rural Route Number		ate, Zip Code) yland 21702
e,	1 and Heelt em 2		20a. Method of Disposition		20b. F	Place of Dispo	osition (Name of U	NK !	Date UNK	20c. Location - Cit	
nor	ages int of t; if it		1 Burial 2 Cremation 4 Donation 5 Other (emetery, cre	matory or other place	е)			
Baltimore,	permit. Pages 1 Department of P Important; if ite any injury or ot once.		21. Signature of Funeral Service			2	2. Name and Addres	s of Facility			, Illinois
Ba	Depa tmpo any i		Rachmond	Polas	1 001				Staurier		ome Maryland 21702
			23a. Part1. Enter the disease, o	r complications that cause	d the deat						Approximate
I	Physician		shock of heart failure. Lis Immediate Cause (Final disease or condition	tonly one cause on each	L(51	VK	M CAS) -	TOD	4/11/12	In an	Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as	s a conseq	uence of):	,	14	[V # 17]	W.	ן און ניטוויוזון
20	Examiner		Coquentially list conditions	b					700	γ.Λ.°	
16	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseq	uence of):			10%	pr	
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last) c							
8760,	cian s	ũ	rosumy in dodiny cast	Due to (or as	s a conseq	uence of):		Λ	Just of		
87	physic	dlcal		d					10 TO		
9 xo	deeth certific e attending p id for use as i	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of oregon	ancy		Y	MAL		
Bo	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 🗆 Feta	if déath 3[Ectopic pregnancy Other (specify)		1	23d. Date o Month	
o.		ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	it timo or c	,oa,,, 5 t					
<u>α</u>	law requires thet the as been signed by th 2 should be detache		Part If. Other significant conditi	ions contributing to death	but not res	utting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contribu	ute to the cause of death?
Records,	quires n sign	d by							10	Yes 2- No 3[Probably 4 Unknown
00	w requii s been s should	Completed							24a. Was	an 24b. Wei	re autopsy findings available
Re	The lavate has	E								rmed? dea	
Vital	ician: Tector, p	0	25. Was case referred to medical	af				26. Place	of Death (Check only of		Yes 2 No
>	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 2	ER/Outpatie	nt 3 DOA Othe	ar	sing Home 5 Resid		(Specify)
J Of	ng Ph ter th neral		27. Manner of Death	28a. Date of Inj	ury av Year)	28b. Time o	28c. Injury Work			now injury occurred	
0	andir sath. or: Af he fu	atlo	Jan 100 Idolik	igation (a/7/	16	1248	PM 10		BACKED	OVER DY	IVEHICLE
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be mined 28e Place of Ir building	ijtry - At h	ome, farm, st fy)	reet, factory, office		28f. Location (S City or Tox	Street and Number of	or Rural Route Number,
	itai o ars af rai D				P	OWE			FREDE	DUC MD)
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	edical	29a. Certifier 1 Certifyi (Check only 2 Medica	ing Physician: To the bes I Examiner: On the basis and manner s	#f examina	owledge, deat ation and/or in	h occurred at the tim vestigation, in my or	ne, date and pinion, deat	d place, and due to the h occurred at the time.	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	o the ithin 2 o the	Mec	29b. Signature and title of certific	//	tateu.		29c. License	number		29d. Date sig/fed (A	Month, Day, Year)
	F 3 F 8			Mit	1		1/1	101	9	6/7	104
7	6		30. Name and address of person	who domained cause of	death (Iter	n 23a) (Tuna	Print)	700	, ,	0/7	100
	7)		BRIAN R	4002 D.T)	47) W. 7	74) (T FRE	DEVICK	MD ZIZIOI
4	Sta		31. Date filed (Month, Day, Year	1 2 2006 32. Re	rar's Signa	ature	Coole			V	7
3	Registi	वा	0011			/	1				

			For State Registrar	State o	of Marylan	id / Depa	artment o	of Hea	ith and	Mental Hy		06	199	966
			Decedent's Name (First, Middle	, Last)						2. Date of Dea	Reg. No. ath	_	3. Time of	Death
П	Physici		77'	Lynn	Sweer	1617				Month June	Day	Year		
	/Medic Examin		4a. Facility Name (If not institution,			ТСУ	4b. City, Tov	vn. or Loc	ation of Dea		8 , 2 4c. Count	006	3:30	Р
П	⊨xamır	er	Calvert Memor						rederi		Calv			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		Under 24 Hr			_	place (State o	r Foreign
Н	Funeral Director		212-68-0130	1□M 2▼F	50				ours Min		7, Year) 1056	Cou	ington	
			Usual Residence of Decedent							TAIL 11	,1000	Wasi	iiigtoi.	1, 100
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation	_					10d. Inside Cit	y Limits
	Mar Mar	tor	MD Cal	vert	Ch.	esapea	ike Bea	ch					1 X Yes	2 🗌 No
	h the	Director	10e. Street and Number			-	10f. Zip Co	de			10g. Citizen of	What Coul	ntry?	
	th wil		3609 11th	Street				2073	32		U.	S.A.		
	dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13.	Was Decedent	of Hispar	nic Origin? (Specify Yes or No- rto Rican, etc.)		ce - Americ		
٥	or Ite		1 ☐ Never Married 2 🔀 Marri		2 V No		1 ⊡ Yes 2 X		ecify:	no nican, etc.)		ck, White,		
5-0036	72 hours after death with the Maryland natural', or ttems 23a or 28a-f show jical Esta circer and be nuffined at	d by	3 Widowed 4 Divorced	Year or D	ates:		103 24	140 32	becny.		Specif	y: wh	nite	
ភ	n 72 hours after death with the Marylan "natural", or Items 23s or 28s-1 show solical Extra clust fee notified at	Completed	15. Decedent (Specify only highes			(Give	dent's Usual O kind of work of	one durini	g most of wo	orking	16b. Kind of B	lusiness/In	dustry	
2	d within giene. ir than "	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use r							
7			12 17. Father's Name (First, Middle, I	and)		lnve	estigat	1	8.4.45 - 4. 84.		U.S. Go		ment_	
Maryland	be d la la la la la la la la la la la la la	Be						18.		me (First, Middle,	Maiden Sumar		-	
Ĕ	2 should to and Ment Is marked	70	Elmer Norris	McConke	<u> </u>	101 14 111			Mar			Wind		
<u> </u>	s 1 and 2 should f Health and Mer itam 27 Is marks other traumatic		19a. Informant's Name/Relationsh							ural Route Numbe				
	s 1 and if Health itam 27 other to	,	Joseph Michael S 20a. Method of Disposition	weeney, k	20b. P	3609	11th sition (Name o	rf.	eet, C	hesapeak	e Beach 20c. Location			
ğ	iges or o		1 X Burial 2 Cremation		State	emetery, crer	natory or other	place)	1			•		
altimore,	t. Partmer		`4 □ Donation 5 □ Other (Sp		Ches		e High]			3-2006 I	Port Rep	publi	c, MD	
E E	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service L	licensee	/		. Name and A			- 70 3	0 '	150	2072	_
	UU = 4 G		Doya!	(all	ach					e, P.A.,		, MD	20736	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	only one\cause on	each line.								Approximate Interval Betwonset Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	- a. Relup	se of Ir	Siltret.	ing Directo	J Br	east C	archome	A.		2 40	
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):	,							
		-	Sequentially list conditions,	b. — Due to	(or as a consequ	uanaa of):								
	led nsit	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10	(or as a consequ	uerice oi).								
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	c	(or as a consequ	uence of):								
9/60	ate be executed hysician and the burial-transit					,								
280	ate the	edical	- V	d										
	w requires that the death certific been signed by the attending p should be detached for use as		IF FEMALE:	23c. If yes, ou	tcome of pregna	incy					22d Do	to of dolling		
X Q Q	atter atter I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live t	oirth 2 Fetal	Ideath 3	Ectopic pregn Other (specif					te of delive onth	*	ear
j.	the d y the	lys	1 □ Yes 2 2 No 9 □ Unknown	9□ Unkn			, and topour	/						
7	that led b		Part II. Other significant condition	ns contributing to d	eath but not resu	ulting in the ur	nderlying caus	given in	Part I.	23e. Did to	bacco use cont	tribute to th	ne cause of de	ath?
g	juires n sigr	d by	Breast Carano	atthe ism	multip	le met	ustuses	40		1 □ Y	es 2 No	3 Prob	ably 4 □Ui	nknown
Ö	> 0 8	lete	Breast Carano Brain,	Liver !	Bone - 1	vertepro	ie. Cin	trales	teral	24a. Was a	n 24h	Were auto	psy findings a	vailable
Vital Records,	ding Physician: The lav h. After this certificate has funeral director, page 2	Completed						-6081		autops	SV		npletion of ca	
Ø	ificat or, pa	e C	25. Was case referred to medical								2 X No	1 🗌 Yes	2 No	
	Physician: rthis certific ral director,	o B	examiner?	Hospital:	Inpatient 2	ER/Outpatien	20 004			ath (Check only or				
o	Phy or this aral o	-	27. Manner of Death	28a. Date	of Injury	28b. Time of		njury at Work?	☐ Nursing i	dome 5 Resid			′)	
DIVISION	th. : Afte	the state	Natural 5 Pending investig		th, Day Year)	Injury		Work? 1 ∐ Yes	2 🗌 No		, , , , , , , , , , , , , , , , , , , ,			
18	Attar dea actor	flca	3 Suicide 6 Could n	ot be 28e. Place	of Injury - At ho	me, farm, stre	et, factory, of	ice		28f. Location (S	treet and Numb	er or Rura	l Route Numb	er.
5	al or afte Dira d in t	Certification:	4 Homicide	build	ng, etc. (Specify	1)				City or Town	n, State)			
	spit hours mara y fille		29a. Certifier 1 Certifying	Physician: To the	best of my know	wledge, death	occurred at th	e time, da	ate and place	and due to the c	ause(s) and ma	nner as st	ated.	
	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	edical	(Check only 2 Medical E	xaminer: On the b	asis of examinat ner stated.	tion and/or inv	estigation, in r	ny opinior	n, death occi	urred at the time, d	ate and place,	and due to	the cause(s)	
	To tl withii To th comp	Me	29b. Signature and title of certifier				29c. Lie	ense num	nber	2	9d. Date signer	d (Month, I	Day, Year)	
			General F	Iteme	n mo		\mathcal{L}	17:	245		Time	9	2006	
	. 6		30. Name and address of person v			23a) (Type,								
	10		Gerald P. Ste					ach R	Rd. Ea	st. Owing	as. MD	20736		
	Sta	te	31. Date filed (Month, Day, Year)	1 2 2006	legistras Signal	ture	1.	9 0			رسد رجر			
	Registr	ar	JUN	1 2 2006	Blocker	s st.	Moare							

					nt in Black In aryland / Depa			-	_	е.			
			1 - For State Registrar			rtificate of			3. No.2 0 0	6 19967			
1	Physic	an	Decedent's Name (First, Middle, La	ist)				2. Date of Death Month	Day Yo	3. Time of Death			
	/Medi		Helen Faye Sumner					June 9,	2006	10:00 A M			
7	Examir	ner	10005 00 - 4 - 4										
		200	10205 Mar Rock Dr 5. Social Security Number 6.5		e (In yrs. last birthday)	Months Days Hours Min.		9. Date of Righ	Washin				
*	Funeral Director		220-32-5926	1□M 2ĬF	67 Yrs.			8. Date of Birth (Month, Day,) Oct 31,		Birthplace (State or Foreign Country) irginia			
21215-0036	rytand	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
	the Marylan 28a-f ehow	cto	Maryland Washing			1 ☐ Yes 2 ☐ No							
	or 2	Fig	10e. Street and Number 10f. Zip Code						g. Citizen of Wha	at Country?			
	ath w	rai	10205 Mar Rock Dr			21740			USA				
	within 72 hours after death with the Maryland ane. then "naturel", or items 23a or 28a-f ehow the Medical Examinat must be molified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Forces?	1 Tyes 2 No		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:			American Indian, White, etc.			
	uret.	d b	3 XWidowed 4 □ Divorced	Year or Dates:						Vhite			
	net net	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Business/Industry				
	withii then	μř	Elementary/Secondary (0-12)	College (1-4or 5	5+)		0)		Grocery Store				
	filed Hygid ther	ပို							le, Maiden Sumame)				
an	d be ental ked c	To Be	Tyler Frank Stult	Z			Ocie Rub	v Foster					
Maryland	Shou M M mar	-	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	and Number or Rura		City or Town, Sta	ite, Zip Code)			
ž	nd 2 lith a 27 is r tra		Edward D. Rollins/Partner 10205 Mar Rock Drive Hagerstown, MD 21740										
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatth and Mental Hygiene. Importants if item 27 is marked other then "naturel", or items 23a or 28a-f-ehow any injury or other traumatic event. It Medical Examination must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State										
Baltimore,			1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 06/10/06 Beltsville, Maryland										
B	Physician /Medical		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AVOCAR DIAL ISCHEMIS										
Vital Records, P.O. Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a donsequence of): a consequence of): a consequence of):	1cer				months			
	the death certification the attending place as the death of the ast		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify) 9 □ Unknown							23d. Date of delivery Month Day Year			
	requires that the de: een signed by the a nould be detached t	by	Plant II. Dither significant containing to death but not resulting in the underlying cause given in Part 1.										
	has b	Completed	24a. Was an autopsy performed? death?										
	ician: Th certificete rector, pag	0	25. Was case referred to medical				26 Place of Death	/Check only one)		Yes 2□ No			
>	Physician: this certificantal director, I	To B	examiner?										
ion of	g the factor								be how injury occurred				
Division	al or Atte s after det il Director id in by th	Certification:	3 Suicide 6 Could not to determined	28e. Place of Inj	Injury - At home, farm, street, factory, office etc. (Specify)			28f. Location (Street and Number or Rural Route Numb City or Town, State)					
	o the Mospital or Attendi	Medical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	hysician: To the best miner: On the basis o and manner sta	of my knowledge, death f examination and/or in- ated.	occurred at the tirvestigation, in my o	me, date and place, a ppinion, death occurre	and due to the caused at the time, date	se(s) and manne and place, and	or as stated. due to the cause(s)			
	ithin o the omple	M	29b. Signature and title of certifier			29c. Licens	se number	29d	. Date signed (M	Ionth. Day Year)			

State Registrar

June 9, 2006

Simpleted cause of death (Item 23a) (Type, Print)

JOHNSON DYIVE, FREDERICK MD 21702, A.Z. HEGAZI

32. Resistrar's Signature

ORIGINAL

			1 - For State Registrar	State of M	farylan		artmen rtificat			and M		jiene 19g. No.	200) 6	9	968	
ı	Physici		Decedent's Name (First, Middle, Last	AGNES	ANN	то	PPER		-		2. Date of Dea Month June	1 7 2ay	208)6 16	3. Time of 10:50	Death M	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number	r)		4b. City,	Town, or	Location of	of Death		4c.	County of	Death			
1			St. Catherine'					mits!					redei				
	Funeral Director		5. Social Security Number 6. Se 220–28–8203	х]м 2 <mark>6</mark>]F	199 (In yrs. I 193	last birthday) Yrs.	If Under Months		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day Oct. 10	Year) 19	12 N	Birthi Coul	place (State on ntry) y Land	r Foreign	
	pu »		Usual Residence of Decedent		100 Cib	. Town and											
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f ahow idical Examinar must be notified at	٥	10a. State 10b. County 10c. City, Town or Location Maryland Frederick Emmitsburg										10d. Inside City Limits XX Yes 2 □ No				
		Director	10e. Street and Number 10f. Zip Code 10								Oa. Citiz	en of Wha	at Cou	ntrv?			
		<u></u>	331 South Seton Avenue 21727							_	USA						
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric					ecity Yes or No-	ecify Yes or No- Rican, etc.) 14. Race - American Black, White, etc								
36	or its	y Fu	1 Never Married 2 Married	1 Tes 2 If Yes, Give	ŽNo		1 ☐ Yes		Specify:	, , doi:0	riicari, etc.)		Specify: V				
Ö	hours tural:	q pa	3 □XWidowed 4 □ Divorced 15. Decedent's Edu	Year or Dates	: 1	16a Dece	dant'e Heur	al Occupa	tion								
15	be filed within tal Hygiene. d other than "	plet	(Specify only highest grade completed) (Give kind of work done during most of w					of work	ing	100. KII	b. Kind of Business/Industry						
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Maryland		To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)														
-	ind 2 should alth and Men 27 is marke or traumatic		19a. Informant's Name/Relationship (7) Frances Lingg/								a <i>l Route Number</i> burg, MI		Town, Sta 1727	te, Zip	Code)		
Baltimore,	Pages 1 and of He noted to the If Item into or other into		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		_ C6	lace of Dispo emetery, crer 7 St. S	matory or o	ther place			23, 'OF				own, State MD	,	
Balti	permit. Deportmit. Imports any inju		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Skiles Funeral Home 210 W. Main St., POBox 427, Enamitsburg, MD 21727														
	sicien: The law requires that the death certificate be executed to the law requires that the death certificate hes been signed by the ettending physician and tirector, page 2 should be detached for use as the burial-transit and the law real transit Ical Examiner	23a. Pair Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset in Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											ween				
.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown							2:	23d. Date of delivery Month Day Year						
rds, P.		þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to								bacco use contribute to the cause of death? as 2 No 3 Probably 4 □Unknown						
Il Records,		Completed	au pe								24a. Was a autops perform	prior to completion of cause of death?					
Vital	Iclan: Sertific ector.	Be	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Wursi								eath (Check only one)						
of o	Physician: rthis certific ral director.	£									g Home 5 ☐ Residence 6 ☐ Other (Specify)						
o o	Attending ir death. ector: After by the fune	t lo	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 8 Work? 1 Yes 2 No								28d. Describe how injury occurred						
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
_	the Hospital or hin 24 hours efte the Funeral Dir npletely filled in	alC	29a. Certifier 1 Fortifying Phy	sician: To the bes	t of my knov	wled je, death	n occurred	at the tim	e date and	d place.	and due to the ca	ause(s) a	ind manne	ar as of	Paled		
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Exami	ner: On the basis and manner s	of examinati stated.	ion and/or in	vestigation.	in my op	inion, deat	h occurr	ed at the time, da	ate and	place, and	due to	the cause(s)		
	To t To t	2	29b. Signature and title of centifier		au	all	290	: License	number 8	70	5 2	9d. Date	signed (A	Aonth,	Day, Year) O 6		
	5		30. Name and address of person who co Alan Carroll, M.D.					308	, Emm	itsb	ourg, MD	21	727			,	
	Sta Registr		31. Date liled (Month, Pay, Year) 3 20	32. Regis	trar's Signat	D A	mile	,									

			1 For State Registrar			f Marylan		artmen rtificat					Reg. No.	000	16 199	6
	Physici /Medic		1. Decedent's Name (First, M Joyce	Ela		Tal	bert					2. Date of De Month June 8	Day		3. Time of Dea 6:15 p	
	Examin	er	4a. Facility Name (If not instit	ution, give	street and nun	nber)		4b. City,	Town, or	Location of	of Death			County of De		
_			327 Green: 5. Social Security Number	Ldge :		7. Age (In yrs.	last hirthday		Dunk 1 Year	irk If Under	24 Hrs.	8. Date of Bir		ne Ar	undel Birthplace (State or Foi	minn.
	Funeral Director		376–12–4853			7. Age (m y/s. 84	Yrs.	Months	Days	Hours	Min.	Month, Da Dec. 2	y, Year)		Country) Michigan	eign
	ס		Usual Residence of Deceder									DCC. Z	, ,,			
	anylar ehow	_	10a. State 10b. Co	,	ndo]		y, Town or Lo Dunkirl								10d. Inside City Lit 1 ☐ Yes 2 ☒	
	the M	Director	MD Anne	e Aru	nder	1	JULIKILI	10f. Zip	Codo	_	-		10a Citi	zen of What		1110
	Mith Sa or		327 Greenr	daa	Drive			101. 21		20754	1		rog. Oili	U.S.A	•	
	death me 2:	Funeral	11. Marital Status	Luge	12. Was Dece	dent Ever in U	.S. 13.	Was Dece				offy Yes or No Rican, etc.)	-	14. Race - A	merican Indian,	
٥	after or its		1 Never Married 2		Armed For 1 ☐ Yes If Yes, Giv	2 X No		irtes,spex 1 □ Yes		n, mexicar Specify:		tican, etc.)		Black, W Specify:		
2-003b	n 72 hours after death with the Maryland "natural; or iteme 23e or 28e-f ehow edical Examinat must be notified at	d by	3 Widowed 4 □ Divo		Year or Da	ates:									white	
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7 7	d within jiene. r than "	mo.	Elementary/Secondary (0- 12	12)	College (1	-4or 5+)	forms						U.S.	Gove	rnment	
ana	be filed tal Hygi d other event, I	Bec	17. Father's Name (First, Mic	die, Last)						18. Mothe	er's Name	(First, Middle,				
<u>X</u>	should but nd Ment	2		Lliam		on					ılah	Ire			ser	
Ma	0 a = 2		19a. Informant's Name/Rela									Route Number			e, Zip Code)	
d)	1 and Health tem 27 other tr		Richard W. To	imer	L, SOII	20b. F	Place of Dispo	sition (Nar	ne of		Fall	fax, V		22030	or Town, State	
aitimor	permit. Pages 1 Department of H Important: If Ite eny injury or ot once.		1 Burial 2 ☐ Cremate 4 ☐ Donation 5 ☐ Other			State	vetera Vetera	,			15 3	2006		.tenhar		
	mit. F partmy porter / injur		21. Signature of Funeral Ser		_	עורז		2. Name an				2000	<u> </u>	.cemai	II, PID	
ñ	Depa Impo eny ir		Fry	2/1	Neck	ach	Rá	ausch	Fune	eral	Home,	P.A.,	, Owi	ings, l	MD 20736	
	Physician		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or comp List only o	lications that can be cause on ea	ach line.	h. Do not ent		1			respiratory ai			Approximate Interval Between Onset and Death	
	/Medical Examiner				Due to (or as a conseq	uence of):									
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	{	Due to (or as a conseq	uence of):									
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JS, F	requires thet the een signed by th hould be detache	Ď	Part II. Other significant cor	ditions co	ntributing to de	eath but not res	ulting in the u	nderlying c	ause give	n in Part I.		1	obacco u		to the cause of death	
ecords,	w requ been shoul	ete										24a. Was				
пат же	The lay ate hes page 2	Completed										autop		prior t death 1 \(\supers	autopsy findings availa o completion of cause ? es 2 \(\square\) No	of
X	Phyaicien: Th this certificate rai director, pag	9 Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☑ No	-	Hospital:	npatient 2	ER/Outpatier		Othe			(Check only o				
ō	g Phy er this eral d	n: To	27. Manner of Death			of Injury h, Day Year)	28b. Time of		8c. Injury Work	at Nu		e Resid			pecify)	
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DIVISION	spital or Attending I ours after death. Neral Director: After filled in by the funer	Certification:		ould not be termined	28e. Place buildin	of Injury - At hong, etc. (Specif	ome, farm, str y)	eet, factory	, office		28	Bf. Location (5 City or Tox	Street and vn, State)	d Number or	Rural Route Number,	
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: / completely filled in by the ti	edical (29a. Certifier Cert (Check only 2 Med	ifying Phy ical Exam	sician: To the iner: On the ba and mann	best of my knousis of examination stated.	wledge, death tion and/or in	h occurred vestigation	at the tim	e, date an	d place, ar th occurred	nd due to the d d at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
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				1/					D	3317	45		6 -	9-06		
	10		30. Name and address of pe						7.4	U210	Than - 1	T	.d'	ale im	20670	
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			State of Maryland / Department	artment of Health and Me rtificate of Death	•	e2006 19970
	Physici /Medio		1. Decedent's Name (First, Middle, Last) LUCY IWI)	2.	. Date of Death	Vear Suppose S
	Examir Funeral	er	4a. Facility Name (If not institution, give street and number) 6 2 6 6 7 8 8 7 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9	4b. City, Town, or Location of Death SAL 5 B U F If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth	4c. County of Death W C D M C O 9. Birthplace (State or Foreign Country)
	Director		092−22−3238		(Month, Day, Yea)3-22-191	1 POCOMOKE, MD.
	h the Maryl or 28a-f eho	Director	MD WICOMICO SALISBUE		10g. (1% Yes 2 No Citizen of What Country?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exami	by Funeral D	1 Never Married 2 Married 1 ☐ Yes 2 1 No	21801 Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2√√2 No Specify:	y Yes or No- can, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	within 72 hou ene. than "natura the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) RIOR DESIGNER		Kind of Business/Industry LF EMPLOYED
Maryland 2	should be filed nd Mental Hygi marked other umatic event, il	To Be Co	17. Father's Name (First, Middle, Last) THOMAS NORMAN TULL	18. Mother's Name (F LENA BARNE	First, Middle, Maide	
	1 and 2 sho Health and tem 27 is m		HUGH HANSON -ATTORNEY P.O.	BOX 101 SALISBURY, sition (Name of Date	MARYLAND	
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		Y_Bunal 2 □ Cremation 3 □ Removal from State 14 □ Donation 5 □ Other (Specify) PITTS CRE	TEK CEMETERY 06-15-0 Name and Address of Facility BOUND		OMOKE, MARYLAND
8760,	Physician /Medical Examiner e parial-transit e parial-transit	dicai Examiner	23a. Party. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cads on each line.	705 EAST MAIN STREET ter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
Vital Records, P.O. Box 68	the death certify the attending iched for use a	by Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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al Reco	ician: The law r certificate has be ector, page 2 sh	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vit	Phys this al dii	ation: To Be	25. Was case referred to medical examiner? 1			6 □Other (Specify) ury occurred
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invand manner stated. 29b. Signature and title of certifier	vestigation, in my opinion, death occurred a	at the time, date ar	nd place, and due to the cause(s)
			Virginia A Willamy In D 30. Name and address of person who completed cause of death (Item 23a) (Type.	D0033905	- 5	LISBURY Md 21802
	Sta	te	VNCINIA A. DUIANY M. 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature) KO130x 290	49 SA	USBURY Md
	Registr		JUN 1 2 2006	book		

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 2006 7:05 p.^M Pier van Gorkum June 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Village Nursing Home Frostburg Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 175-40-7238 81 Yrs. Jan. 5, 1925 Amsterdam, Hollan Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f show the Medical Exporter rount be notified at Director 1 ☐ Yes 2 X No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HC 72, Box 246 26726 USA filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 📉 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Electrical Project Engineer Electrical Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mental H tant: If Itam 27 is marked oth jury or other treumatic even Be Anne van Gorkum Sophia Westerveld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Cunningham/Friend/POA HC 72, Box 240 Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State June 26 2006 permit. Page Depertment of Important: If any Injury or 2005. 4 □ Donation 5 □ Other (Specify) Potomac Memorial Gardens Keyser, WV 22. Name and Address of Facility Smith Funeral Home 21. Signature of Funeral Service Licensee Kerean 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Severe dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner heimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical phys the L IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28d. Describe how injury occurred Division 5 Pending 1 Natural within 24 hours efter death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Fo the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6-19-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Tarn Terrace S.L. Sandhir, M.D. Frostburg, MD 21532 31. Date filed (Month, Day, Year) 32. Angistrar's Signatu State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Ralph Edward West 18 2006 2327 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 109 Anderson Avenue Havre de Grace
If Under 1 Year | Il Under 24 Hrs. Harkord 8. Date of Birth (Month, Day, Year) 02/23/1932 Birthplece (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1**X** M 2□F Days Hours 229-34-2453 Director 74 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Itama 23a or 28a-f ehow traumatic evant, the Mudical Exaction must be notified at 1 Yes 2 □ No Funeral Director MD Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Anderson Avenue USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1□Yes 🞾 No Specify Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 9th Electrician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Carl West Charlotte Tibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 of Health Joyce M. West- Wife 109 Anderson Avenue, Havre de Grace MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any injury or once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harkord Mem. Grdns. 06/22/06 Aberdeen, MD 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas this certificate 1 Tes 2 No 2 No 1 Yes o the Hospitel or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home Residence 6 Other (Specify) 70 1 🗌 Yes 20 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Hatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rso o completed cause of death (Item 23a) (Type, Print) 3t. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 **Physician** Month Year Jeraldine P. Whitmore June 04 ам 600 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery Silver Spring 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months | Days | Hours | Min. | Min. | July 26, 1926 Missouri 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Director 500-22-4691 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Md. Lanham PG1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 9116 Wallace Road Funeral 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Black þ 3 ₩ Widowed 4 Divorced "neturef", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 is marked other then "n any injury or other treumatic event, the Mealt once. College (1-4or 5+) Elementary/Secondary (0-12) Smithsonian Inst. 4yrs Executive Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert A.Perkins Edythe L. Redd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6 3 0 4 0 19a. Informant's Name/Relationship (Type, Print) 564 Beacon Point Lane, Wildwood Missouri Marjorie Terrell(Sister) 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem 06-09-06 Brentwood Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Washington DC Tyrone J. Young 719 Kennedy St. NW 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal failure 36 hours /Medical Due to (or as a consequence of) **Examiner** Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 7days Due to for as a consequence of Examiner inding physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the e Division of Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 【 ☐ Unknown Gangrene of feet Completed Hepatic Failure 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1

Inpatient 2 □ ER/Outpatient 1 ☐ Yes 2X No ဥ 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation Injury efter death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗍 Homicide To the Hospital or within 24 hours eft 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21153 MD June 06,2006 5 30. Nam and address a pers who completed cause of death (Item 23a) (Type, Print) Spring, Md 20904 Garry Rupen 11120 New Hampshire Ave#101 Silver 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 9 2006 Registrar

06-04012 Patrick West

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate	of Death Re	_{eg No} 2006 1997
Physicia Medical Exami	4611	Decedent's Name (First, Middle,Last) Portrain on Manager Handle, Po	2. Date of Deal Month	Day Year
manage of the second		Patrice Vaughn West 4a. Facility Name (if not institution, give street and number)	June 11, 2 4b. City, Town, or Location of Death	4c. County of Death
,		Prince Georges County Jail	Upper Marlboro	Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Mantha Dava Have Me	th(MM/DD/YYYY) 9 Birthplace (State or Foreign
Birector		577-96-9455 1X M 2 F 44 Usual Residence of Decedent	Yrs. 09/0/	/1961 CouWalsh., DC
any		10a. State 10b. County 10c. City, Town or Lo	ocation	10d Inside City Limits
daryland 28a-f show any datonce.	٥	Maryland Prince George's	Coral Hills	1 Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene n 27 is marked other than "natural", or items 2.3n or 28a-f show umatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 4601 Heath St.	10f. Zip Code 11 20743	Og. Citizen of What Country? United States
ms 23s	eral		Was Decedent of Hispanic Origin? (Specify Yes or No	
ter deat	Fun	1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 Y No specify:	White, etc. African Specify: Amondo an
ours af atural	d by	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	dent's Usual Occupation (Give kind of work done	American 16b. Kind of Business/Industry
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5-0036 led within 72 Hygiene other than the Medical	omo	12th 17. Father's Name (First, Middle, Last)	Security 18.Mother's Name (First, Middle, M	Private Private
21215-0036 buld be filed within 7 Mental Hygiene marked other than c event, the Medica	BeC	John Henry West		ne Vaughn
221 hould I nd Mer is mar	2	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	alling Address (Street and Number or Rural Route Num	nber, City or Town, State, Zip Code)
imore, MD 21215-003 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene lant: If item 27 is marked other the or other traumatic event, the Med	-	Lorrine West/Mother 4 20a Method of Disposition 20b Place of Dis	601 Heath St., Coral Hill position (Name of cemetery, Date	S. MD 20743
Baltimore, MI permit Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		1 X Burial 2 Cremation 3 Removal from State crematory o	r other place)	
altim nit Pa artmer sortan iry or				Suitland, MD
III Per B		John T. Silving III		Funeral Home Wash., DC 20019
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not ent		Between Onset and
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		Sequentially list conditions, b.		
	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
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760, icate be physical the burn		IF FEMALE: 23c. If yes, outcome of pregnancy	erME.g858.8/3/06 TT	23d. Date of delivery
certificanding	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy	Month Day Year
Box 68; he death certifi the attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)	
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Vital Rec ysician: The his certificate director, page	ပ	25. Was case referred to medical	1 ✓ Yes : 26.Place of Death (Check only one)	2 No 1 Yes 2 No
Vita hysicia this cel al direct	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Other —	Residence 6 🗸 Other: Scene
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been sed in by the funeral director, page 2 should the control of the cont	ä	27. Manner of Death 1 X Natural 5 Deading (Month, Day, Year) 28b. Time		now injury occurred
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death or one) 2 Medical Examiner: On the basis of examination and/or invest		
To t with To t	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Tobillos AR.	O.C.M.E.	June 12, 2006
		30. Name and address of person who completed cause of death (Item 23a)		
			Penn Street, Baltimore, MD 21201	
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32.	(i)	
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	ehov	5			100.0									10d. Inside City Limits 1 1 1 Yes 2 1 No
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<u>8</u>	Ment Ment arked atice	To	Robert Webb						L€	enoi	a News	ome		
<u>Ja</u>	2 short and reum		19a. Informant's Name/Relationship (Brenda L. Web)	** *							Route Number			
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	4		30. Name and address of person who				,							
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5	Sta Registr		31. Date filed (Month, Day, Year) JUN 9 206	16 P. Hegis	sIrar's Sign	ature	er i							

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H			ene	6 19976
1 2	Physicia /Medic		1. Decedent's Name (First, Middle SEATRICE	e, Last)	WAR	2		2. Date of Death Month	Day Ye	3. Time of Death
	Examin Funeral		4a. Facility Name (If not institution Anne Arundel 1 5. Social Security Number 577–44–4911	Medical Cent			apolis	S. 8. Date of Birth (Month, Day,	Year) 9.	Arundel Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L		ewater	July 20,	1932 W	ashington, DC 10d. Inside City Limits 1 □ Yes 2 ※No
with the Ma	a or 28a-f	Funeral Director	10e. Street and Number 4046 Honeysuck			10f. Zip Code	21037	10	g. Citizen of What Country? U.S.A.	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year June 7, 2006 9:40 a M Warman Annie Sansbury /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 262 Sansbury Road Friendship Anne Arundel 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country)
Sept 30,1916 Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Yrs. Director 214-14-0028 89 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other then "neturel", or items 23s or 28s-1 show other treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Friendship Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20758 262 Sansbury Road USA filed within 72 hours after deeth v Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marita! Status Black, White, etc. 1 □Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Specify: ģ 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 homemaker own home Pages 1 and 2 should be filed venent of Heelth and Mental Hygie and; if item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Irene Selina Sansbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4707 Levada Terrace, Rockville, MD 20853 John S. Warman, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages:
Department of IImportant; if its
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 06-08-06 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William R. NOn Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic Myocardovpathy years **Physician** /Medical Examiner Securitielly list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Be Completed Anemia - colon Cecal mass 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Renal Fallure Drubetes melitus Ta Chronic 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred s efter des. rei Director: Afte 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours e To the Funerel (**Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sterner mp D17245 June 7. 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald P. Sterner, M.D., Calvert Arundel Medical Center, Owings, MD 20736 32. Registrate Signature 31. Date filed (Month, Day, Year) State JUN - 8 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Nò. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician June 7, 2006 5:40 Bessie Marcus Yecies /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Bethesda Montgomery Brighton Gardens If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 🗓 F Yrs. 05/22/1915 91 Hungary Director 175-05-8059 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County the Medical Examiner must be notified at 1 XYes 2 No Director or 28a-f 1 PA Pittsburgh Allegheny 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 5715 Beacon Street # 217 15217 USA e filed within 72 hours after death val Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Secretary County permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Itsm 27 is marked othn any injury or other traumatic event, sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Marcus Isadore Marcus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10613 Willowbrook Drive Potomac, MD 20854 Mark L. Yecies/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Shalom Cemetery 06/11/2006 Pittsburgh, PA 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Lice 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroselarotu Chrebrovaxular Mosease **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed use as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): ettending physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached Records, P.O. signed by the 9 Unknown 9 Unknown Part I, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner?
1 \(\text{Yes} \) 2 \(\text{No} \) No 26. Place of Danth (Check only one) Other: 4 Distursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending death. М 1 Tes 2 No To the Hospitel or Attend within 24 hours after death. To the Funerel Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check only one) 29b. Signature 31. Date filed (Month, Day, Year) sistrar's Signature State Registrar

			For State Registrar	State of Maryland		rtment of He tificate of D			iene 2006	19979
*K	Physici /Medic		Decedent's Name (First, Middle, Last) Euge	enia	Ziso	covici		June 3		3. Time of Death 5:40p м
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	Funeral Director		33233.2.1	7. Age (In yrs. la M 2 12 5 3	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day, March	Q Birt	nplace (State or Foreign untrice Comania
	aryland ehow		Usual Residence of Decedent 10a. State 10b. County MD Monto		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the M la or 28a-f Lbe notifie	i Director	10e. Street and Number 5922 Empire W	omery Jay	, KC	ockville 10f. Zip Code 20	0852	1	0g. Citizen of What Co US	untry?
980	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "neturel", or iteme 23a or 28a-f ehow event, the Medical Exercities reast by notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces?, 1	i	Vas Decedent of His Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036	. 10	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. L	ent's Usual Occupat kind of work done du DO NOT use retired) Homema		ing	16b. Kind of Business/	-
	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Mi	To Be Co	17. Father's Name (First, Middle, Last) Nicolai Ionii	ta		1			Maiden Sumame) Ionita	
Maryland		1	19a. Informant's Name/Relationship (Ty, Silviu Ziscov	pe, Print) Vici spouse	19b. Mailin 5922	g Address (Street and Empire	Way Ro	al Route Number	City or Town, State, 2 e MD 2085	(ip Code) 2
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny Injury or other 1		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State Coll	ce of Dispo netery, cren UMD1 a	sition (Name of latory or other place) a Garden	s 06/0	7/2005	20c. Location - City or Arlingt	
Balti	permit. Departn Importe eny Inju		21. Signature of uneral/Service License	Enter 9			of Facility EV	enry Con	Falls Chi	
Sec.	Pnysician		23a. Part1. Enter the disease of complications, or heart failure. List only or immediate Cause (Finat disease or condition resulting in death)			or the mode of dying,			est,	Approximate Interval Between Onset and Death 6 years
	/Medical Examiner		Sequentially list conditions	Due to (or as a conseque						
	and J-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
68760,	tificate be executed g physician and as the burial-transit	dicalE		I						
P.O. Box 6	ne death cer the attendir thed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea	leath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
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	5 E	tion: To	1 Yes 2 XNo 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	I Inpatient 2 LE	R/Outpatient 8b. Time of Injury	28c. Injury a Work?	4 🗀 Nursing Ho		nce 6 Other (Spec w injury occurred	ify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Surcide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ι e, far m, stre	et, factory, office		28f. Location (Str City or Town	reet and Number or Ru. , State)	ral Route Number,
)	Hospit 24 hours Funeral letely fille	Medical ((Check only 2 Madical Examin	ilcian: To the best of my knowler: On the basis of examination and manner stated.	adge, Jeath in and/or inv	occurred at the time estigation, in my opin	, date and place, nion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	Within To th compi	Me	29b. Signa ura and title of contribi	llo MC)	29c. License r	531	29 j	Od. Date signed (Month	
			G. Peter Push	mpleted cause of death (Item 2 151) 32. Registrar's Signatu	(Type, F	old Ge	orgetan	Rogol	Rocki	16 MD 285
3.	Sta Registi		31. Date filed (Month, Day, Year) JUN 9	32. Registrar's Signatu	K A	parte	•		·	

Eugenia Ziscovizi 6/3/06 1843

06-04230

Please Type or Print in Black Indelible Ink

Harold Brown State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registra 2. Date of Death Physician/ 1414 hrs Medical Examiner June 18, 2006 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Johns Hopkins Bayview If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Numbe If Under 1 Year **Funeral** Foreign Director Usual Residence of Decedent any 10h County Town or Location Yes 2 No or items 23a or 28a-f show must be notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. funt: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother than must be moffield at once, or other trannatic event. the Medical Examiner must be noffield at once. Director 10a. Citizen of What Country Funeral Was Decedent Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black White, etc Armed Forces? Never Married 2 Yes 1 Yes 2 No specify. If Yes, Give Year Divorced Widowed ģ Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Complet 21215-0036 Be Mailing Address MD Lepartment c Important: I. Other Specify 21. Signati Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter Physician Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED death certificate be Box 68760. 23c. If yes, outcome of pregnancy 23d Date of delivery 3b Was decedent pregnant in the Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o ģ 1 Yes 2 No 3 Probably 4 Unknown σ. Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performe Yes Yes 2 V No 2 No 26. Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medica of Vital Be Other Nursing Home 5 Residence 6 Inpatient 2 CR/Outpatient 3 DOA After this 1 🗸 Yes 2 No ۵ 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 V Natural 1 Yes 2 No Division Pending death Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2Bf. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined To the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E June 21, 2006 ril 30. Name and a ress of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD 31. Date filed (Month) Day Year) gistrar's Signature State 6 2006

Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🖓 🕕 🕤 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 31 PM 2006 Richard Henry Blomquist, Jr. lune /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Doctor's Community Hospital Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ★M 2 □ F 217-48-3456 59 Director 09/12/1946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Kichard Henry Albmquist, Ir. Baltimore, Maryland 21215-0036 item 27 is marked other than "natural", or itema 23a or 28e-f show other traumatic event, the Madical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 Smith Road 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 √ No Specify: Specify: White δ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if Item 27 is marked other than any injury or other traumatic event, the Magnetial Pages. Elementary/Secondary (0-12) College (1-4or 5+) Lockheed Martin Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Henry Blomquist, Sr. Janet M. Craiq 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine E. Rittner, Daughter 1775 Tremainsville Road, Toledo, OH 43613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mamorial Park 06/28/2006 Elkridge, MD 21. Signature of Funeral Service Licensee -22. Name and Address of Facility -dry L. Kaufman Funeral Home at Meadowridge Memorial Park, IN 7250 Washington Biva., Elkridge, MD 21075 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCAROUA 2 hours /Medical Due to (or as a consequence of): Examiner Sacurations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit that initiated events resulting in death) Last law requires that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 ptonths? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 Yes 2 No 1 TYes Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifica lely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Other: 1 ☐ Yes 2 V No 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital of within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) MDD61131 who completed cause of death (Item 23a) (Type, Print) 575 Main St. Suite 351 Laurel, MD 20707 MD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JUN 2 6 2006 Registrar DHMH 17 Rev 1/2001

06-04327 Juanita Faye Ba	uah		se Type or F				a		
Joanna i aye be		- For State		ificate of Dea		entai riygien	Reg. No.	201	16 1998
Physici		Registrar 1. Decedent's Name (First, Middle,Last)				2. Date Mont	of Death	Year	3. Time of Death
Medical Exami		Juanita Faye Baughe				June	20, 2006		2202 hrs
		4a. Facility Name (If not institution, give street and 1248 Armistead Way	number)	Balt	, Town, or Locat imore			c. County of Deat	
Funeral Director		5. Social Security Number 6. Sex 1 M 2XX	7. Age (In yrs. las	t birthday) If Ur Mon Yrs.			e of Birth(MM /17/194	Forei	rthplace (State or gn gn puntry)Virginia
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mannell Hygiens I mortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other fraumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed		If Yes, spe	cify Cuban, Mex	Origin? (Specify Ye ican, Puerto Rican, e		White, etc.	rican Indian, Black,
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21 Should and Me 'is ma	ပ	19a. Informant's Name/Relationship (Type, Print)				Number or Rural Ro Drive, Je			
MD 2 sho and 2 sho salth and em 27 is		Ronnie Baugher (Son) 20a. Method of Disposition	20b. P	lace of Disposition (N				Location - City o	
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Baltimore, permit. Pages I ar Department of Hee Important: If ite njury or other tr		Donation 5 Other Specify:	Bay	OO Name a		anilia.			, Maryland
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To the Hospital or Att
within 24 hours after de
To the Funeral Direct
completely filled in by 3

Medical Certific

State Registrar

3 Suicide

Homicide 29a. Certifier 1 (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 21, 2006

32. Registrar's Signature

Francis Joseph Breighner

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

rancis Joseph I		1- For State Certificate of Death	rivientai Hygiene Reg No.	2006 1998
Physicia ledical Exami			2. Date of Death Month Day June 18, 2006	Year 3. Time of Death 0721 hrs
A Commence of the Commence of			Location of Death 4c. Cou	inty of Death more County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yr Months Day 1. Age (In yrs. last birthday) Yrs.		YYY) 9. Birthplace (State or Foreign Country) Maryland
he Maryland or 28a-f show any ifted at once	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 21050		10d. Inside City Limits 1 Yes 2 No f What Country? J.S.A.
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Completed by Funeral		panic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) Specify: Specify: Specifor (Give kind of work done DO NOT use retired)	Race - American Indian, Black, White, etc. White
21215-0036 Auld be filed within 7: Mental Hygiene. marked other than e event, the Medical	o Be Con	17. Father's Name (First, Middle, Last) Francis Joseph Breighner, III 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Str.)	18.Mother's Name (First, Middle, Maiden Surna Gail Lynn Shenton t and Number or Rural Route Number, City or T	
Baltimore, MD 21215-000; pernit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Med.	Ξ.	Francis Breighner, III (Father) 11937 Glen A 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Holly Hill Mem.	m Road, Glen Arm, Mar	ryland 21057 on-City or Town, State timore, Maryland
Physician /Medical Txaminer	Examiner	23a. Part Later the disease, or complications that caused the death. Do not enter the mode of dyin failure. List only one cause on each line. Imm diate Cause (Final disease or indition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiac arrhythmia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	such as cardiac or respiratory arrest, shock, or	heart Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Medical	d. X UNPENDED AMENDED item#23a-b,27,perME,g858,8 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions AMENDED item#23a-b,27,perME,g858,8 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown	Ectopic pregnancy 23d Date Month iven in Part I. 23e. Did tobacco use co	ontribute to the cause of death?
Vital Records, P.C. hysician: The law requires that this certificate has been signed al director, page 2 should be dete	To Be Completed by	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	24a Was an autopsy performed? 1 ✓ Yes 2 No of Death (Check only one) Other Nursing Home 5 Residence	3 Probably 4 V Unknown ib. Were autopsy findings available prior to completion of cause of death? 1 V Yes 2 No
Division of Vital To the Hospital or Attending Physician, within 24 hours after death To the Funeral Director: After this cert completely filled in by the funeral director.	Certification:	or Town, State)	mber or Rural Route Number, City	
To the Ho within 24 To the Fu completel	Medical	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the best of my knowledge, death occurred at the time, one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinic and manner stated. 29b. Signature and title of certifier 29c. Licer O.C	death occurred at the time, date and place, an enumber 29d. Date si	igned (Month, Day, Year)
St	ate	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltin 31. Date filed (Month, Day, Year) 32. Restrar's Signature	ore, MD 21201	
Regist		titus conce for the departs of		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Julie 23 Day 2006 Year 9:00p M Dwight Frazier Brunk, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Oeath Examiner Carroll Hospital Center Carroll Westminster 8. Date of Birth Jan. 25, 1932 Mary Land If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Oays Hours 1⊠M 2□F 74 215-30-8919 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 289-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Reisterstown Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1114 Cockeysmill Rd. 21136 "natural", or items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 Mayes 2 □ Norean 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after to Hygiene.
I Hygiene.
other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) District Manager Suburban Propane 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic event pice. Dwight F. Brunk Mary Naomi Wehrenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1114 Cockeysmill Rd., Reisterstown, Md. 21136 Anna M. Brunk - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Gardens June 27,2006 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of tonela 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia Harte **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed monic Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No cate has t 24a. Was an autopsy performe Division of Vital 1 Yes 2 1 No 25. Was case referred medical 26. Place of Death | Check only one examiner? Hospital 1 Yes 2 No Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After Certification: 28d. Describe how injury occurred Natural 5 Pending after death.
Director: Af 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 39502

10 State Registrar

31. Date filed (Month, Day, Year) JUN 2 6 2006

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447, Bast Main st bestmister Ans mus 32. Registrar's Signature

MD

d address of person who completed cause of death (Item 23a) (Type, Print) (to sain

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** cuae ne Barnett June 1035AM /Medical $2cd_{2}$ 4a. Facility Name (I) not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death listown Novyhwes pital (enter Baltimore If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Feb. 21, Year 936 7. Age (In yrs. last birthday)
70 yrs 6 Sex If Under 1 Year **Funeral** 9. Birthplace (State or Foreign Months Days Hours 10XM 2□ F Min. Maryland Director Yrs. 217-30-4964 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County th and Mental Hygiene. ?7 is marked other than "naturel", or iteme 23a or 28a-f shov treumatic event, the Madical Examinar must be notified at or 28a-f show 10d. Inside City Limits Maryland Baltimore Arbutus Director 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5526 Willys Ave. 21227 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: Specify: 3 ☐ Widowed 4 🎇 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Roofer Construction 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Frank Barnett, Sr. 2 Nettie Citro 19a Informant's Name/Relationship (Type, Print) Gene Barnett, son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5526 Willys Ave. Arbutus, MD. Health t item 2 20b. Place of Disposition (Name of competery, crematory or other place)
West Arundel Crematory 6-26-2006 20a. Method of Disposition 20c. Location - City or Town, State ŏ Depertment of important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** atherosclerotic cardiovasculai /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit law requires that the death certiticate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4☐ Pregnant at time of death Month Dav Year P.O. I 5 Other (specify) ate has been signed by the page 2 should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À Completed 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Matural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the tu death. investigation 2 Accident 1 Tyes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0052760 line 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 old court Road Randallstern Muldrow, MD RICH 10B/M Maryland 21133 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Francis Paul Benevicz 1:00 A M /Medical 2006 June 20, 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7312 Berkshire Road Dundalk Baltimore Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1**∑**M 2□F Yrs Director 220-07-9786 85 Feb. 14,1921 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location rthan "natural", or items 23a or 28a-f show the Madical Examiner rust be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7312 Berkshire Road death v Funeral 21224 United States 12. Was Decedent Ever in U.S. Amned Forces? 1≜]Yes 2 □ No If Yes, Give Year or Dates: WWI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 28 No þ Specify: Specify: 3 ₩ Widowed 4 Divorced White WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Maintenance Man Proctor & Gamble Co. permit. Pages 1 and 2 should be file
Department of Health and Mental Hy
Important: If Nem 27 is marked othe
eny injury or other traumetr 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Paul Benevicz Josephine Kohanski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis P. Benevicz (Son) 69 Seafarer Lane Ocean Pines, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6/23/2006 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk. 7922 Wise Ave. Dundalk, Maryland 21222 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mesothelioma Yzar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner Tany, leading to in hedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The taw requires that the death certificate be executed and sicien ar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical thet phy as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Dav Year 4 Pregnant at time of death signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 ☐Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 X No 1 Yes 2 XNo or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural s after death. 2 No 1 Tyes in by the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in o the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Z Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oncology Fellow D0060046 2006 30. Name and address of person who complet a cause of death (Item 23a) (Type, Print) Mesaltimore, Maryland 21231 401 32 Registrar's Signature Year State Registrar

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1100	/Medi	cal	Leonard 4a. Facility Name (If not institution, gi	Geo	rge	Bay	er or Location of Death	June	24 2006	1:00 A M
	Examir	ner							4c. County of Death	
	Funeral		615 South 47 th 5. Social Security Number 6.	Sex 7. Age (In)	yrs. last birthday	If Under 1 Year		8. Date of Birth	Baltimor	e lace (State or Foreign htry)
	Director		213-20-6791 Usual Residence of Decedent	1 M 2 F	81 Yrs.	Months Days	Hours Min.	(Month, Day, Sept. 2	5 1924 Mar	yland
	yland		10a. State 10b. County	10c	. City, Town or L	ocation			1	0d. Inside City Limits
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	or 28	Oire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cour	itry?
	ath w	rai	615 South 47'th	Street		21224			U.S.	Α.
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Haalth and Mental Hygiene. Item 27 is marked other than "neturel", or items 23s or 28s-1 ehow other treumstic event, the Medical Eventral Function	Funeral Director	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	irs aft	by F	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	4.0
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Maryland 21215-0036	giene The	Completed	9	NA NA	Mecha	anic Auto	mobile		Schaefer &	Strominger
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Jar	2 sh and ls m		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Number,	City or Town, State, Zip	Code)
	of Health item 27	1		Wife)	615	South 47	th Stree		ore, Maryla	
altimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition t ☐ Burial 2 ☐ Cremation 3 [Removal from State		osition (Name of matory or other pla		e 27,	20c. Location - City or To	wn, State
ŧπ	t. Pa rtmen rtant: njury		4 Donation 5 Other (Special			Heart of	Jesus	2006	Dundalk, Ma	ryland
Ba	permit. Pages Department of Important: If it ony injury or once.		21. Signature of Fulleral Service Lice	Champer	Re 1	2. Name and Addre W. Dabrov OO5 Dund	ess of Facility WSki/Choji alk Ave	nacki Fu	neral Homes e, Maryland	P.A.
	that the death certificate be executed Weddical Exam detached for use as the burial-transit	licai Examiner	shock/or heart failure. List only Immediate (Cause (Final disease or condition resulting in death) Sequentially list conditions, I am a little cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons	sequence of):	ncer				Interval Between Onset and Death
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ري ح	res that igned b	by Pi	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to the	e cause of death?
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<u> </u>	iicien: Th certificate rector, pag	Bec	25. Was case referred to medical			72.0	26. Place of Death		1	2 □ No
<u> </u>	Physicien: r this certifica ral director, p	To	examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3 DOA Oth			nce 6 Other (Specify)
	ding P		27. Manner of Death 1 √2 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of	28c. Injur Wor		28d. Describe hov		
20		ati	2 Accident investigation	n			Yes 2 □No			
DIVISION	To the Hospital or Attan within 24 hours after deat To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
:	To the Mosp within 24 hou To the Funer completely fil	edicai	29a Certifier 1 Certifying Pl (Check only one) 2 Medical Example	hysician: To the best of my k miner: On the basis of exam and manner stated.	knowledge death ination and/or in	socianed at the tin vestigation, in my o	ne, data and place, a pinion, death occurre	and due to the ear	ase(s) and manner as sta te and place, and due to	the cause(s)
ĺ	withi To t	×	29b. Signature and title of certifier	1115		29c. Licens		29	d. Date signed (Month, D	lay, Year)
			+ Th Te			020	2517	-	June 25, 200	16
	10		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)	a. ich		omo >	
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Sig	plature for	di)	200		01-00	1000
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State of Maryland / Department of Health and Mental Hygiene

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Physici dical Exami	an/	1. Decedent's Name (First, Middle, Last) Robert Castle TII		2. Date of Death Month June 9, 20	h Day Year	3. Time of Death 1613 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr.	s. 8. Date of Birt		nplace (State or
Director		245.86.4030 1XM 2 F 34 Yr	Months Days Hours Mir	06.28	. 19771 Foreign	ntry) MD
' any		Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Local				10d. Inside City Limits
ryland a-f show	tor	MD N/A Baltin	70/C T10f, Zip Code	10)g. Citizen of What Coun	1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	417 S. Gilmor Street	21223		USA	иу:
eath with items 2. ust be n	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S 13. W	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
hours after de 'natural'', or Examiner m	by F.	to Dates.	Yes 2 No specify:		Contract of the Contract of th	reasian
72 hour n "natu sal Exan	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	nt's Usual Occupation (Give kind of nost of working life, DO NOT use ret	ired)	16b. Kind of Business/Ir	•
5-0036 led within 72 Hygiene other than the Medical	dwo	Sthande N/A CONS	Truction Work	EV (First, Middle, M	Mc Mann	Painting
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tht and Mental Hygiene n 27 is marked other than "natural", or items 23a or 28a-f sho numatic event, the Medical Examiner must be notified at once	Be C	Robert Castle, Jr.	Jouce	Barre	ett	
nore, MD 2121 ages I and 2 should be fi nt of Health and Mental nt: If item 27 is marked other traumatic event,	P P	19a Informant's Name/Relationship (Type, Print), Robert Cautle, In/Father 7810	g Address (Street and Number or Chesapeake	3	asadua N	
or Hea		1 Burial 2 Cremation 3 Removal from State crematory or o	sition (Name of cemetery, ther place)	Date	20c. Location - City or	own, State
of target of tar		4 Donation 5 Other Specify: LOUGOS 21. Signature of Funeral Seguce Licensee 22.	n Park 06 Name and Address of Facility	16 06	Baltime	ore MID
	١.,	23a. art I. En er the disease, or complications that caused the death. Do not enter	Name and Address of Facility Ompussion Funer 9-1215. Struker	Street	Balto. MD	21223 Approximate Interval
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Hanking	the mode of dying, such as cardiae of	or respiratory arre	st, shock, of fleat	Between Onset and Death
LXammer		or condition resulting in death) Due to (or as a consequence of):				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
rted J ansit	Examiner	events resulting in death) Last Due to (or as a consequence of): d.	- **-			
be execu ician and urial - tra	Medical	X UNPENDED X AMENDED item#1,23a,27,28a	a-f,perME,g857,7/27/0)6 TT		
68760 certificate b nding physic se as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Figure 1	etal death 3 Ectopic pregn	ancy	23d. Date of delivery Month D	ay Y ear
Aecords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physici	Dreamont at time of death	ther (Specify)			:
P.O. I	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute to the	ne cause of death?
in of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach				24a. Was a	an 24b. Were aut	opsy findings available
Division of Vital Records, ral or attending Physician: The law requirs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should!	Completed			autops perform 1 V Yes 2	med? death?	mpletion of cause of No
/ital sician: is certifi lirector,	o Be (25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatien	26.Place of Death (Check		Residence 6 Other:	
ision of Vital Attending Physician: r death. ector: After this certif by the funeral director.		27. Manner of Death 1 Neture (Month, Day, Year) 28b. Time of (Month, Day, Year)	Injury 28c. Injury at Work?		low injury occurred	
r Attencter death	Certification:	2 Accident Investigation 28e Place of Injury - At home farm stre		28f. Location (\$	hanged self Street and Number or Run	al Route Number, City
Diversity of tilled i	Certi	Suicide 6 Could not be determined (Specify) Baltimore Centrical Countries Co	ral Booking	Baltimore	tate) 300 E. Madis	son Street
Division To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated				
E » E »	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mon	th, Day, Year)
		30 Name and address of person who co pleted cause of death (Item 23a)	J.J.IVI.L.		June 10, 2006	
			enn Street, Baltimore, MD 2	21201		
S Regis	tate	and the	market			

OCMF 2006

ORIGINAL

06-04287 Bi

Please Type or Print in Black Indelible Ink

illy Condron, Jr	State of Maryland / Departr	ment of Health and Mental Hy icate of Death	7111	16 1998	
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last) Pilly Too Condron Tr	oato or Boain	Reg. No. 2. Date of Death Month Day Year June 19, 2006	3. Time of Death 1445 hrs	
mally	4a. Facility Name (if not institution, give street and number) Bowie Health Center	4b. City, Town, or Location of Death Bowie	4c. County of Dea Prince Georg	je's	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last to 220-72-0424 1X M 2 F 48	Months Days Hours Min	Feb. 25,1958		
uh the Maryland 23a or 28a-f show any notified at once.	MD Poltimore I Tans	on or Location sdowne 10f. Zip Code	10g. Citizen of What Co	10d Inside City Limits 1 Yes 2 X No untry?	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland b and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shematic event, the Nedroal Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	21227 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	rican Indian, Black,	
72 hours after "natural", al Examiner	3 Widowed 4 Divorced in Yes, Give Year or Dates:	1 Yes XX No specify: a. Decedent's Usual Occupation (Give kind of we during most of working life. DO NOT use retired.)	ork done 16b Kind of Business	ite //Industry	
215-0036 be filed within 72 hours at natal Hygiene riked other than "natural ent, the Medical Examin Be Completed by	17. I differ 5 Name (1 if 51, Middle, Ed3t)	Carpenter 18.Mother's Name Mable N	(First, Middle, Maiden Surname)		
imore, MD 21216 Pages 1 and 2 should be fill ment of Heath and Mental H sant: If item 27 is marked, or other traumaric event, I To Be	19a Informant's Name/Relationship (Type, Print) Debbie Condron, wife	19b. Mailing Address (Street and Number or F 411 Second Avenue	ural Route Number, City or Town, Sta Baltimore, MD 212	227	
Baltimore, Department of Heal Important: If iten injury or other tra	Debbie Condron, wife Solution State Sta				
Physician injury	21 Inature of Funeral Service Licensee Light Unit 23a. Part I. Inter the disease, or complications that caused the death. Do	22 Name and Address of Facility Gary L. Kaufman Fu 7250 Washington Bl not enter the mode of dying, such as cardiac of	.vd. Elkridge, MI	21075 Approximate Interval	
/Medical Examiner	failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Asphyxia Due to (or as a consequence of):			Between Onset and Death	
ed nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last		- Indiana		
re execut cian and nrial - tra					
Sox 6876C leath certificate a attending phys for use as the b	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregna	23d Date of deliver	ry Day Year	
JS, P.O. B quires that the d cen signed by the uld be detached		ting in the underlying cause given in Part I.		the cause of death? babbly 4 Unknown utopsy findings available	
tal Record tian: The law re certificate has be ector, page 2 sho	autopsy performed? 1 Ves 2 No 1 Ves 2				
of Vital I ing Physician: After this certifi uneral director,	examiner? 1 Ves 2 No 1 No Hospital: 1 Inpatient 2 VER 27 Manner of Death 288 Date of Injury 28	DOA Other Nursin b. Time of Injury 28c. Injury at Work?	g Home 5 Residence 6 Oth 28d. Describe how injury occurred	er:	
24a. Was an autopsy performed? 1 Ves 2 No 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28. Date of Injury 28. Date of Injury 28. Injury at Work? 29. No 28. Date of Injury 28. Injury at Work? 29. No 28. Date of Injury 28. Injury at Work? 29. No 28. Date of Injury 28. Injury at Work? 28. Date of Injury 28. Injury at Work? 29. No 28. Place of Death 29. Date of Injury 28. Injury at Work? 28. Date of Injury 28. Injury at Work? 28. Date of Injury 28. Injury at Work? 28. Date of Injury 28. Place of Injury 3 Subject chocked while eating 28. Place of Injury 28. Place of Injury 28. Place of Injury 3 Subject chocked while eating 28. Place of Injury 28. Place of Injury 28. Place of Injury 3 Subject chocked while eating 28. Place of Injury 28. Place of Injury 28. Place of Injury 28. Place of Injury 28. Place of Injury 3 Subject chocked while eating 28. Place of Injury 29. Place of Injury 29. Place of Injury 29. Place of Injury 29. Place of Injury 29. Place of Injury 29. Place of In					
To the Hospital within 24 hours To the Funeral completely filled		death occurred at the time, date and place, and	due to the cause(s) and manner as sta		
Fara	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed _{(M} June 20, 2006	onth, Day,Year)	
17	30. Name and address of person who completed cause of death (Item 23 Ana Rubio MD. Assistant Medical Examiner 11	^{a)} 1 Penn Street, Baltimore, MD 21201			

State 31. Date filed (Month, Day, Year) JUN 2 6 2006 Registrar

32. Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? [] [] [1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June LUELLA BIVENS CORNELL 10:27A [™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heart Homes of Lutherville Lutherville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | March | 12,1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 217-32-6390 71 Yrs. Director Mary l'and Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location of Health and Mental Hygiene. Item 27 le marked other then "natural", or Iteme 23a or 28a-1 show other traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Felton Road 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 Tes XX No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Principal Edcation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Douglas Maxwell Bivens Luella Elizabeth Dowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evart Frantz Cornell 202 Felton Road Lutherville, Maryland 21093 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If tte any injury or ot once. 1 Burial XXCremation 3 Removal from State GreenMount Crematory 6/26/06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician**)ementia disease or condition resulting in death) ears /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, any, locally control of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence of): Examine The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetel death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 🔲 Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? death? 1 Yes 2 🔲 No efter death.

Director: After this certific 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 025205 who co pleted cause of de th (Item 23a) (Type, Print) N. Charles St. Bulto md 21204 6701 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

Henry Nathaniel Davenport

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State of Maryland / De	partment of Health and Mental Hygiene

		1- For State Registrar	Certifi	icate of Death		R	eg No.	200	6 199
Physici ledical Exam		1 GIV	thaniel Day	JENDOR	+	2. Date of Dea Month June 18, 2	Day 2006	Year	3. Time of Death 0113 hrs
		4a. Facility Name (if hot institutio 717 Druid Park Lake [Baltimo	wn, or Location of D ore	eath	4c. Cou	inty of Death	
Funeral Director		5. Social Security Number 220-64-3554 Usual Residence of Decedent	6. Sex 7. Age (In yrs. last b	oirthday) If Under Months Yrs.	1 Year if Under 2 Days Hours	4Hrs. 8. Date of Bir Min. 8-14	th(MM/DD/Y	YYY) 9. Birth Foreign Coun	virginia /
Maryland 28a-f show any d at once.	or	10a. State 10b. County	Ba	vn or Location It imore					10d. Inside City Limits 1 Ses 2 No
ith the Maryland 23a or 28a-f she notified at once	I Director	10e. Street and Number 727 Druio	L Par IC (ake	DR. 10f. Zip C	1216		U	f What Countr	y?
ifter death wi	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify (of Hispanic Origin? Cuban, Mexican, Pu No specify:	? (Specify Yes or No lerto Rican, etc.)		Vhite, etc.	an Indian, Black,
15-0036 filed within 72 hours after death with the Maryland I Hygiewill do not a death of the Maryland of the than "natural", or items 23a or 28a-fish of the Medical Examiner must be notified at once	Completed b	15. Decedent's Education (Spec Elementary/Secondary (0-12)		a. Decedent's Usual Oc during most of workin	ng life. DO NOT use		-	of Business/Ind	dustry 54 Electric
e, MD 21215-0036 I and 2 should be filed within 72 Health and Mondal Hygiens item 27 is marked other than item 27 is marked other than item 27 is marked other than	Be	17 Father's Name (First, Middle, Pau Dave	1 DORT		18.Mother's N	ame (First, Middle, M	laiden Surna	kso/	\mathcal{O}
e, MD 212's and 2 should be Health and Menta item 27 is market traumatic event	To	19a. In Jan ame/Relationsl Cuttis R. Da 20a Method of Disposition	went port 12	19b. Mailing Address 4815 But e of Disposition (Name	autor	Tor Rural Route Num	Bal	to.MI	1 21215
Baltimore, permit. Pages la Department of He Important: If ite injury or other to			3 Removal from State creme	e of Disposition (Name latory or other place)	Metery (-23-06 con esta	Cum	besla	d Virginia
면 링크트를 Physician	_		complications that caused the death. Do	not enter the mode of o	York dyling, such as cardi	Load, B ac or respiratory arre	ist, shock, or	heart	Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Multiple injuries Due to (or as a consequence of):					-	Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):						
executed an and al - transit	I Examiner	(Disease or injury trial initiated events resulting in death) Last	Due to (or as a consequence of): d.			-			
š u –	n/Medical	X UNPENDED	X AMENDED item#9,23a,2		E,g856,6/29	/06 TT			
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be, within 24 hours after death. To the Functor: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 No 9 Unk	e 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death	2 Fetal death 5 Other (Specify		egnancy	23d Date Month	e of delivery h Day	y Year
P.O. I	þ	Part II. Other significant conditi	ons contributing to death but not resulti	ing in the underlying ca	use given in Part I.				e cause of death?
of Vital Records, g Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed					24a. Was a autops perform	ned?		osy findings available inpletion of cause of
tal Fician:	Be	25. Was case referred to medical examiner?	Hagnitali		Place of Death (Che				
of Vi g Phys fter this	<u>و</u>	1 Yes 2 No 27. Manner of Death	I Inpatient 2 ER/C	Outpatient 3 DOA D. Time of Injury 286	Injury at Work?	rsing Home 5 F		6 Other So curred	cene
ion ttendin feath. tor: A	atior	1 Natural 5 Pend 2 Accident Inves		:04 am	Yes 2 No	subject j	umped f	rom balc	cony
Division pital or Attendi ours after death.	Certification:	3 X Suicide 6 Could determ	d not be mined 28e. Place of Injury - At home, (Specify) residence	farm, street, factory, of	fice building, etc.	28f. Location (Son Town, St. Apt. 1505	reet and Nur ate) /I/ Baltimo	Druid Pa ore, MD	Route Number City ark Lake Dr.
Fo the Hos within 24 h Fo the Fun completely	Medical	one) 2 Medical Exam	nysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated						
	Σ	29b. Signature and title of certifier	12		ocense number		29d Date si June 18,	igned (Month, 2006	Day, Year)
		30. Name and address of person Mary G. Ripple MD.	who completed cause of death (Item 23a) Deputy Chief Medical Examine		reet, Baltimore	, MD 21201			
St Regist		31. Date filed (Month, Day, Year)	32. Redistrar's Signature	Sporte					
				•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1052 PM June 21 aven 20 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimara Hosp, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day **Funeral** Days Hours Min 216-36-2103 Usual Residence of Decedent 1 ☐ M 2 💢 F Yrs. Maru land Director an. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 □ No Funeral Director nior 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 21 . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Beatrice M. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ke omema 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ac 210 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,2121 00 importent: if item eny injury or other ance. 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 □Removal from State Forest 4 ☐ Donation 5 ☐ Other (Specify) Son 21. Signature of Funeral Service Licensee 22. Name and Address of acility Joseph L RUS ZZZZ W. North Home, P.A. Md. 21216 Funeral W. North Ave. Balto. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the dis shock or heart fail tmmediate Cause (Final **Physician** Acute Myoca-dial disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury Due to (or as a onsequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1∐ Yes 21 No Division of Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner2
1 2 8s 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 Coutpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1- Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerei D 1 Carifying Physician: To the best of my knowledge death conursed at the time date and date and due to the rause(s) and it a wer as stated
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Known as:

State Registrar 31. Date filed (Month, Day, Year)

Patrick

Mc Ginl

2401 west Belvedore ave, Baltimore, MD 21215 32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

MO

ORIGINAL

10054482

June 21, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per inf 9857 7-11-06 yt.

State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 2. Oate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2:56 P M Dickerson 22 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1timore Randallstown Northwest Hospiter Center If Under 1 Year If Under 24 Hrs. 8. Date of 1971 Year Hours Min. (Month, 987, Year) 9. Birthplace (State or Foreign Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF 214=18=0468 Usual Residence of Decedent Yrs. Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "neturel", or Iteme 23a or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mantal Hygiene. Important: If item 27 le marked other then "neturel", or Iteme 23a or 28e-1 ehow empt ingry or other treumatic event, Ita Medical Examinar must be notified at once. 1 Yes 2 □ No Mary land Directo a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 14. Race 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: B Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) person 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (jalloway James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 21/33 Vonne Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 2006 Mem. Park 4 Donation 5 Dother (Specify) Entombment King 23a. Pant/ Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)

a. Multiple organ system failure. 22. Name and Address of Facility
Joseph L. Russ 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Physician /Medical Multiple organ system
Due to (or as a consequence of): Examiner inflammatory response slemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the usum retinings or concern, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Gastrointestina Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, atrial Physician/Medical Chronic IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Month 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronar autopsy performed/ yes 2 No Chronic Kidner disease 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medi all examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 028462

Registrar

DHMH 17 Rev 1/2001

State

SISLOW

JUN 2 6 2006

Boston

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northwest

32. Registrar's Signature

Hospita

June 22, 2006

Maryland 21133

Center Randallstown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \cap \cap \cap$ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 10:18 a w June 23, 2006 Naomi A. Dierksen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel Glen Burnie
If Under 1 Year | If Under 24 Hrs. Baltimore Washington Medical Center 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Days 1 □ M 2 💢 F Months Hours Min 91 Director 1914 217-05-1652 6, Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hyglene. Important: if Item 27 is a marked other than "naturel", or items 23s or 28a-f show any injury or other traumatic avent, the Medical Examples must be notilled at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director DE Sussex Millville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Old Mill Road 19970 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Service **Retail** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert W. Ridinger Blanche E. Stem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karl Dierksen - Son 1877 Poplar Ridge Rd., Pasadena, MD 21122 20b. Place of Disposition (Name of commetery, crematory or other place)
St. James United
Methodist Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06-27-06 4 ☐ Donation 5 ☐ Other (Specify) Dennings, MD 22. Name and Address of Facilit Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee any ir 1328 Sulphur Spring Rd., Arbutus, MD 21227 nepust 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physicien er Division of Vital Records, P.O. Box 68760, ician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the the 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 s 2 1No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 0 No 2 ER/Outpatient ٩ 1 Yes 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 Tes 2 No investigation Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funersi 29a Certifier cai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar rcompleted cause of seath (Item 23a) (Type, Pa

32. Registrar's Signature

MD

			For State Registrar	State of Mary		artment of H			giene 2 () (16 19995			
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Y	3. Time of Death			
	Physici: /Medic	al	Hazel Pauline Doug					JUNE	22 2	006 3.00 FM			
A. Carrier	Examin		4a. Facility Name (If not institution, give st SAINT AGNES	treet and number)	ITAL	BA	LT 1 M C	RE	4c. County of n/a	l .			
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (III M 2☑F	n yrs. last birthday) 79 Yrs.	Il Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day April 2	(7, 1927)	Birthplace (State or Foreign Country) West Virginia			
			Usual Residence of Decedent										
	arylan ehow	_	10a. State 10b. County	10	oc. City, Town or Lo Baltim					10d. Inside City Limits 1 Yes 2 No			
	he Mi	Director	MD N/A 10e. Street and Number		Daltin	10f, Zip Code			10g. Citizen of Wha				
	with Se or	ם בי	2814 Carroll St.			21230			United S				
36	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene. Hem 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, I'm Medical Examinat must be inclified at other traumatic event, I'm Medical Examinat must be inclified at	by Funerai		2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White			
Ş	2 hou		15. Decedent's Educ	ation		dent's Usual Occup	nation during most of work	ina	16b. Kind of Busin	ess/Industry			
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired Maker	d)	y	Own hom				
21	led will stand with the standard the standar		17. Father's Name (First, Middle, Last)		поше	: Makel	18 Mother's Nam	a /First Middle	Maiden Sumame)	16			
anc	d be fi	o Be	Paul Baer					1 Stros					
Maryland 21215-0036	should nd Me mark	၉	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	r, City or Town, Sta	ate, Zip Code)						
Š	alth a alth a 27 is		LeRoy A. Dougherty	, Jr. /hus	band 281	4 Carrol	l St. Bal	timore,	Maryland	21227			
ore	ges 1 and to the tree or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	1	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	ce)	Date	20c. Location - Cit	315			
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Baltimore,	permit Page Department of Important: if any in ury or		21. Signature of Fugeral Service License	Mualio	2	719 Hammo	nds Ferry	Rd Lan	sdowne, N				
			23a. Part T. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the e cause on each line.	e death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	ACUTE	MYO	ARDIA	AL INT	ARCI	,	HOURS			
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):	BIADT	TO	DARC	101001	A WENDS			
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9	n certificate anding phys use as the	an a	IF FEMALE:	3c. If yes, outcome of	oregona ocy				204 5-1-				
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۳.	requires that the de been signed by the e hould be detached f	/ Ph	Part II. Other significant conditions con	23e. Did to	id tobacco use contribute to the cause of death?								
ds,	8 50	d by	COBONARY	ARTER	Y DIS	EASE		101	23d. Date of delivery Month Day Year tobacco use contribute to the cause of death? Yes 2 \[No \] 3 \[Probably \] 4 Munknown an 24b, Were autopsy findings available				
Division of Vital Records	e law hes b	Completed							rmed? pric	r to completion of cause of th?			
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes th (Check only o		Yes 2X No			
>	d is	To B	examiner? 1 X Yes 2 No	ospital: 1 X Inpatient	2 ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing Ho	ome 5 ☐ Resid	tence 6 Other	(Specify)			
o uo	Attending Pr r death. ector: After th by the funeral		27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	Wor	ryat rk? Yes 2 □ No	28d. Describe h	now injury occurred				
Divis	for Atter after des Director	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	reet, factory, office		281. Location (5 City or Tox		or Rural Route Number,			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical C			st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the								
	To the within 2. To the f	Med	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (I	Month, Day, Year)			
	/.		1	M	d.	P1761	02	-	JUNE &	12, 200E			
C.	17		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type,	Print)							
V	2		RINY KAARAS		N AVENU	E, BALTIN	DRE, MAR	CUANT	21229				
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUN 2 6 20	32. Registrar's	Signature	Carle	ndre, Mar						

PAULINE DOUGHERTY

6/20/2006 8:30 A.M. Himore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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			For State of Many land / Department of Health and N		eg. No. 2 11 11 6	10005			
	g 28	بار	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	tion to the	3. Time of Death			
	Physicia /Medic		John Edward Duffy	June 20, 2006					
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 14 Hillside Road Catonsville		4c. County of Death Baltimore				
	Funeral	***	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign untry)			
	Director		219-18-2650 1 [™] 2□ F 79 Yrs. Months Days Hours Min.	Jan. 28, 1927 Maryland					
pue	*		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
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dt edt	or 28e	Funeral Director	10e. Street and Number 10f. Zip Code	1	log. Citizen of What Co	untry?			
4	23a	rai	14 Hillside Road 21228		USA	day to dia.			
ter de	Item	-une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ★ Married 1 ★ Married 1 ★ Married 2 ★ Married 1 ★ Ma	Rican, etc.)		e, etc.			
2-0030	E I	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII		Specify: Whi	lte			
SEYJISTIC Z 1 Z 1 3-0030 spould be filed within 72 hours after death with the Maryland	uatini Great	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	ang	16b. Kind of Business/	Industry			
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Mary	le ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run						
e ;	Health Fr 27 Ther t				lis Maryl: 20c. Location - City or				
	ayes ant of at: If it		1 Burial 2 Cemetion 3 Removal from State 4 Donation 5 Other (Specify) 1 Burial 2 Cemetery, crematory or other place) 4 Donation 5 Other (Specify) 6/22	2006	Catonsville	, Maryland			
Saltimor	penture ragos i rando associo de ligido. Deperturent of theath and Mental Higher. Important: If item 27 le marked other than "natural", or iteme 23a or 28e-f ehow any injury or other traumatic event, the Modical Exeminer must be notified at once.		21. Signature of uneral Service Licensee 22. Name and Address of Facility Ste Funeral Home of C	rling As	hton Schwa	Witzke			
ם פ	20 2 2 3		1630 Edmondson Av	enue; Ca	tonsville,	MD 21228 Approximate			
			23a. Part 1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arr	est,	interval Between Onset and Death			
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200	death certificates at the distribution of for use as the	Physician/Medic	IF FEMALE:						
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בו בו	after Direct Direct	Certification;	4 Homicide determined building, etc. (Specify)	City or Tow					
9	To the Hospitel of Attending within 24 hours after death. To the Funeral Difector: After completely filled in by the fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur						
1	thin 24	Medical	29b. Signatura/and/title of certifier 29c. License number		29d. Date signed (Monti				
, ,	- 3 ¥ 8 □		Holant hours 056211		6/22/	06			
	14.01		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Salhin	2 110	2.275			
72/5	\v '		JOHN F. ZRWZV (M) SOOLS. HENORY ST. (31. Date filed (Month, Day, Year) JUN 2 6 2006 32 Registrar's Signature	sai nin	are ples	(((()			
	Sta Registi		JUN 2 6 2006						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Extyn 0425 06 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Parkville Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛣 F 215-09-2759 **Director** August 12, 1910 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, 13s Musical Examinar must be notified at Mary land 1 ☐ Yes 2 💢 No Baltimore Parkville Director 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 8810 Walther Boulevard Apt 1513 21234 USA by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0·12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be f and Mental I permit. Pages 1 and 2 should be Department of Health and Menta. Important: If item 27 1s marked, any injury or other traumatic events. Joseph B. Herbst Elizabeth Schoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Slater/Daughter 2616 Chesley Avenue Baltimore Maryland 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/28/06 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leopard J Ruck 1 5305 Hartord Road Included Inc Christia Little 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) vulad **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. SIZNO 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes After this certific funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Deatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending after death.

I Director: Aft d in by the fun investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title JUM 25th 200% 316 30. Name and address operson who completed cause of death (Item 23a) (Type, Print) from waith Renglinan 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)
JUN 2 6 2006

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total.	Registrar 1. Decedent's Name (First, Middle, La	2 \$t)	Certif	icate of D	Jeani	2. Date of Dea		3. Time of Death			
sician edical			FISHER			June	Oy å	0543 AM			
niner	245-78-4889	Sex 7. Age (In yrs.	last birthday) If	Under 1 Year onths Days	Location of Death Time re If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pa) Feb	4c. County of I	Death Birthplace (State or Foreign Country) SC			
ō	Usual Residence of Decedent 10a. State 10b. County MD	10c. Cit	y, Town or Locati		LTIMORE			10d. Inside City Limits 1 □ Yes 2 □ No			
ai Director	10e. Street and Number 1301 WILDWOOD PA	ARKWAY	10f. Zip Code 21229					at Country? U.S.A.			
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates:		Decedent of Hises, specify Cubar	spanic Origin? (Spe h, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - A Black, N Specify:	American Indian, White, etc. Black			
Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)		(Give kind	NOT use retired)	uring most of workir	ng	16b. Kind of Busin	ness/Industry MAILING			
To Be Co							e (First, Middle, Maiden Sumame) LOUVENIA				
	19a. Informant's Name/Relationship JAMES BLAIR SON	(Турв, Print)	1301 WILDWOOD PARKW								
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	oval from State BAYVIEW CREMATORY 06/12/06					y or Town, State MD			
	21. Signature of Funeral Service Lice	ensee M	22. N	ame and Addres Miller"s	Metropolitan	Chapel P.	C. e , Maryland l	21213			
edical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect to or	uence of):								
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past № ponths? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown						23d. Date of delivery Month Day Y				
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Completed			· 	·		24a. Was autop perfor 1 Yes	sy prior dear	re autopsy findings available r to completion of cause of th? Yes 24 No			
Be	25. Was case referred to medical examiner?	Hospital:	£ .	Othe	26. Place of Death						
To To	1 Yes 2 No 27. Mapner of Death Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	4 Li Nursing non	lome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred					
ig ig	3 Suicide 6 □ Could not			factory, office	2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Certification	4 Homicide determine		and due to the nause(s) and manner as stated red at the time, date and place, and due to the cause(s)								
edical Certification:	4 Homicide determine	Physician: To the best of my kn. aminer: On the basis of examina and manner stated.	wiadga death on ation and/or invest	ngation, in my op	pinion, death occurre	ed at the time, o	date and place, and	I due to the cause(s)			
Medical Certification	4 Homicide determine 29a. Certifier Check only 2 Medical Ex	aminer: On the basis of examina	wiadge death on ation and/or invest	29c. License	pinion, death occurre	ed at the time, o	date and place, and 29d. Date signed (A	I due to the cause(s)			
	4 Homicide determine 29a. Certifier (Check only one) 29b. Signature and title of certifier	aminer: On the basis of examina and manner stated.	ation and/or inves	29c. License	pinion, death occurre	ed at the time, o	date and place, and 29d. Date signed (A	due to the cause(s) Month, Day, Year)			

State of Maryland / Department of Health and Mental Hygiene? [] [] [19999 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jüñe 2006 12:40 Am **Physician** Frankenberger Anna Μ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facili G Nem ('Me adiows o'Ndrs inig" Home Examiner Baltimore 11630 Glen Arm Road Apt. 216 Glen Arm If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/04/1914 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 ☐ F Baltimore, MD Yrs. 92 Director 215-09-6722 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow eny injury or other treumatic event, tra Medical Exandrar must be recitified at ODGs. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Glen Arm 1 ☐ Yes 2 No Maryland Baltimore Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21057 Glen Arm Road 11630 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bulter Brothers Secretary 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bauer Anna John Frankenberger ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1240 Winding Oak Drive York, PA 17403 19a. Informant's Name/Relationship (Type, Print) 1240 Margaret Hartman - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/24/2006 Baltimore, Maryland Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) Charles F. Miner 22. Name and Address of Facility 21. Signatul / 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the dis shock, of beart failu Immediate Oruse (Final the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac excespiratory arrest, leaf failure. List only one cause on each line. Approximate Interval Between Onset and Death TERINE ENDOMETRI months **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy USB 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month ō Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknowe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ENSION 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed CARDIAC FAILURE 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed THROM BOSIS 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending P 24 hours after death. Funerel Director: After t Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the P within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AMANA GOPALAN MD 51228 10 EROLLING GOSSROADS State JUN 2 6 2006 Registrar

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)	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City,	Town, or	Location of	of Death		4c.	County of	Death	
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H	Funeral		,	Sex 7. A 1 ☐ M 2 ☐ F		last birthday) Yrs.	Months	1 Year Days	If Under :	Min.	8. Date of Bi (Month, Di	ay, Year)		Count	
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^	s within 72 hours effer death with the Maryland liene. Then "neturel", or tleme 23s or 28e-f ehow The Medical Exerciter must be notified at	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces 1 Yes 2	?_	11	Yes, spec	ofy Cubar	n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	0-		White, e	tc.
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o .	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetal	death 3 🔲	Ectopic pre					2	3d. Date of		ay Year
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	efter of Direct of In Direct of	Certification:	4 Homicide determined		ury - At ho c. <i>(Specif</i> y	me, farm, stre	et, factory,	, office		2	8f. Location (5 City or Tox	Street and vn, State)	Number o	r Rurai F	Route Number,
	To the notation of stranding Physician: The law fequires that the death certificate within 24 hours eller death. To the Funeral Director: After this certificate has been signed by the attending phys complately filled in by the funaral director, page 2 should be detached for use as the	edical C	29a. Certifier 1	nysicien: To the best miner: On the basis o and manner st	t examinat	wiedge, death ion and/or inve	occurred a estigation,	it the time in my opi	, date and nion, death	place, a	nd due to the old at the time,	cause(s) a	and manne place, and	r as state due to th	ed. ne cause(s)
	Withir To th comp	Me	29b. Signature and title of certifier					License				29d. Date	signed (M	onth, Da	y, Year)
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	1		30. Name and address of person who				,						7, 20		
	φ		Joseph Kaplin, M			ter Mi	11 Rd	1. R	ockvi	ille,	, MD 20	855			
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